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The Role of Family Factors in Child Post-Traumatic Stress Disorder (PTSD)

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VOLUME I

Main Research Project and Service Evaluation Project

Federica Corno

2012

Submitted in partial fulfilment of the requirements for the degree of
Doctorate in Clinical Psychology

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OVERVIEW

PART 1

Main research project

THE ROLE OF FAMILY FACTORS IN CHILD POST-TRAUMATIC STRESS DISORDER (PTSD)

Federica Corno

Supervisors: Dr Sean Perrin and Dr Patrick Smith

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ABSTRACT

Background

There is a large body of evidence showing that children experience high levels of Post Traumatic Stress Disorder (PTSD) in the aftermath of a trauma. It is often assumed that the child's response to the trauma is influenced by: i) the parents' own symptomatology; ii) the family's avoidance of trauma reminders and discussion; iii) the general parenting style (e.g. the degree of warmth, criticism and emotional over-involvement); and iv) the general family environment. Given that few attempts have been made to test these hypotheses and research findings have been mixed, determining additional factors affecting children exposed to trauma was important.

Aims and Objectives

The purpose of the present study was to add to the existing literature by looking at family factors and their relation to post-traumatic responding in the child. To address this aim we explored the relationship between the child's self-reported PTSD and: 1) parental expressed emotion; 2) the degree of cohesion, emotional expressiveness and conflict in the family environment; 3) the parent's self-reported symptoms of PTSD, depression and anxiety; and 4) family post-trauma communication.

Method

Twenty-two children (aged 7 – 17 years) exposed to trauma, and their main care-giver, were recruited from child and adolescent mental health services across South-East London. All parents completed self-report measures of PTSD, anxiety and depression, as well as scales rating their child's anxiety and depression. Parental expressed emotion was rated using a five-minute, audio-taped interview where the parent was asked to talk about their child and their relationship. The parents completed the Family Environment Scale (FES) which measures family cohesion, emotional expressiveness, and conflict. The children completed self-report measures of PTSD, anxiety and depression. Finally, children and parents completed a newly-developed questionnaire that assesses their view of the consequences of talking about the trauma in the family.

Results

Contrary to expectations, parental expressed emotion, parental own symptomatology, and the parent's ratings of the degree of family cohesion, conflict, emotional

expressiveness encouraged in the family (measured by the FES) were unrelated to the child's self-reported PTSD symptomatology. However, poor family communication was associated with PTSD symptoms in the child. Overall, the factors found to most strongly relate to the child's PTSD severity were the strength of their own negative trauma-related beliefs and comorbid anxiety and depression.

Conclusions

Little support was found for the widely held view that parental expressed emotion and parenting/family style directly influence the child post-traumatic responding. The best predictor of the child's response was their own trauma-related beliefs. On the other hand, family post-trauma communication directly influenced the child's post-traumatic symptoms levels. Future studies should aim to confirm the findings from the present study and attempt to examine family post-trauma coomunication using multi-method and multi-informant measures in longitudinal and experimental designs.

1. INTRODUCTION

1.1. OVERVIEW

The current study aimed to investigate the dimensions of Expressed Emotion (EE), family environment and parental mental health in parents of children and adolescents with post-traumatic stress disorder (PTSD). There has been very little research to date which has investigated familial/parenting dimensions and childhood PTSD. This study therefore seeks to examine whether the parenting dimensions of criticism and over-involvement (characteristic of EE), the family environment, the family post-trauma communication, and the parent own symptomatology, are associated with childhood PTSD.

This chapter is divided in four parts. Part A describes PTSD in children, including epidemiology, diagnostic issues and theoretical models. Part B reviews the research to date on family issues and parent influences on children with PTSD. Part C looks at the theoretical background of EE as a measure of family functioning. Finally, Part D provides the rationale, aims, objectives, hypotheses and predictions for the present study.

PART A: PTSD IN CHILDREN

1.2 PTSD

The Diagnostic and Statistical Manual (Fourth Edition, Text Revision; DSM-IV-TR; American Psychiatric Association, APA, 2000) defines PTSD as resulting from exposure to a traumatic event that involved actual or threatened death, serious injury, or threat to self or others' physical integrity. The individual's response must have involved intense fear, helplessness or horror. To meet diagnostic criteria for PTSD, the following symptoms must be present for more than 1 month: reexperiencing the traumatic event, avoidance and numbing of general responsiveness, and increased arousal. Details of the three PTSD symptoms clusters are described in Box 1.

Box 1: Diagnostic criteria for PTSD DSM-IV

A. The person has been exposed to a traumatic event in which both of the following were present:
- the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
- the person's response involved intense fear, helplessness, or horror.
Note: In children, this may be expressed instead by disorganised or agitated behaviour

B. The traumatic event is persistently re-experienced in one (or more) of the following ways:
- recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed
- recurrent distressing dreams of the event. Note: In children, there may be frightening dreams without recognisable content
- acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). Note: In young children, trauma specific reenactment may occur
- intense psychological distress at exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event
- physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:
- efforts to avoid thoughts, feelings, or conversations associated with the trauma
- efforts to avoid activities, places, or people that arouse recollections of the trauma
- inability to recall an important aspect of the trauma
- markedly diminished interest or participation in significant activities
- feeling of detachment or estrangement from others
- restricted range of affect (e.g. unable to have loving feelings)
- sense of a foreshortened future (e.g. does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:
- difficulty falling or staying asleep
- irritability or outbursts of anger
- difficulty concentrating
- hypervigilance
- exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning

1.3 PTSD IN CHILDREN AND YOUNG PEOPLE

Psychological symptoms of PTSD are observable in school-aged children and adolescents (Perrin et al, 2004) and there is no age barrier to assigning a diagnosis in children with PTSD (APA, 1994). The core symptoms of PTSD are similar in children and adults (Ehlers et al, 2003; Bryant et al, 2007) namely: intrusive reexperiencing of the event, avoidance/numbing, and hyperarousal. However, language, cognitive capacity, and family influences can all cause variations in the presentation of PTSD during childhood (Meiser-Stedman, 2002; Salmon & Bryant, 2002). For example, very young children, children in middle childhood and adolescents, rarely report the full range of avoidance and numbing symptoms. Re-experiencing symptoms are sometimes expressed in repetitive and trauma-thematic play. Nightmares may be about monsters or separation from parents rather than the trauma. Moreover, very young, traumatised children often display a broad range of somatic and psychological symptoms, representative of anxiety (Giaconia et al, 1995; Bolton et al, 2000; Copeland et al, 2007) disruptive behaviours, attention and academic difficulties (The National Child Traumatic Network [NCTSN], 2009).

An alternative algorithm for diagnosing PTSD in pre-school children has been developed and evaluated by Scheeringa et al (PTSD-AA, 1995, 2001, 2003, 2006, 2011), as shown in Box 2. Research with pre-school and younger children have shown that the PTSD-AA criteria are a sensitive, reliable and valid means of diagnosing very young children's traumatic stress responses (Scheeringa et al, 1995, 2001, 2003, 2006; Ohmi et al, 2002; Meiser-Stedman et al, 2007; Meiser-Stedman, 2008).

Box 2: Scheeringa et al (1995, 2003) alternative criteria for diagnosing PTSD in very young children

A. The person has been exposed to a traumatic event in which he or she experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others

B. The traumatic event is persistently re-experienced in one (or more) of the following ways:
- recurrent and intrusive recollections of the event (but not necessarily distressing), including images, thoughts, or perceptions. Note: in young children, repetitive play or repetitive behaviors may occur in which themes or aspects of the trauma are expressed. Furthermore, recollections may appear not to be distressing in young children
- recurrent distressing dreams of the event. Note: in children, there may be frightening dreams without recognisable content
- acting or feeling as if the traumatic event was recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). Note: In young children, trauma-specific reenactment may occur
- intense psychological distress at exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event
- physiological reactivity on exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by one (or more) of the following:
- efforts to avoid thoughts, feelings, or conversations associated with the trauma
- efforts to avoid activities, places, or people that arouse recollections of the trauma
- inability to recall an important aspect of the trauma
- markedly diminished interest or participation in significant activities. Note: in young children, this is mainly observed as constriction of play
- feelings of detachment or estrangement from others (e.g. unable to have loving feelings). Note: In young children, this may be manifest as social withdrawal
- restricted range of affect
- sense of foreshortened future (e.g. does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:
- difficulty falling or staying asleep
- irritability or outbursts of anger, or extreme temper tantrums in young children
- difficulty concentrating
- hypervigilance
- exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning

1.4 EPIDEMIOLOGY

Estimates of incidence of PTSD in trauma-exposed children and adolescents vary widely in the literature (10% to 90%) (Pynoos et al, 1995; Giaconia et al, 1995; Fletcher, 1996). This variation may reflect differences according to when the PTSD is first assessed, and/or the type of trauma experienced. For example, for road traffic accidents (RTA) rates have been reported to be in the region of 25-30% (Stallard et al, 2004); compared to 51% for a ferry disaster (Yule et al, 2000); and for war refugees 11.5% to 50% (Kinzie et al, 1986; Papageorgiou et al, 2000; Servan-Schreiber et al, 1998). The criteria used to assess children will also affect incidence rates. A recent study found that the incidence rate in children aged two to six years old, who had been involved in a RTA, ranged from 1-2% using DSM IV criteria to 10% using Scheeringa's (2003) criteria (Meiser-Stedman et al, 2005).

Prevalence rates also vary depending on the measurement instruments used, age of the children, and different informants. For example, relying on maternal reports of child PTSD are likely to result in underestimates as children often refrain discussing the traumatic event or its effects with their parents (NICE Guidelines, 2005). This may partly explain the reason for epidemiological studies reliance on self reports from older age samples. In samples of older young adults, lifetime prevalence rates of PTSD have been reported to be approximately 6-10% (Giaconia et al, 1995; Kessler, et al, 1995; Merikangas et al, 2010), with point prevalence rates much lower at 0.4%, with girls out numbering boys 2:1 (Meltzer et al, 2000). However, a recent UK report, the National Survey of Mental Health (Meltzer et al, 2003) found a point prevalence of 0.4% among 11 to 15-year-olds. In line with this, Copeland et al (2007), in a very large, representative, multi-cohort, multi-informant study of 9 to 16-year-olds (the Great Smoky Mountain study) reported a lifetime prevalence of 0.4%. These authors suggest that the developmental insensitivity of the DSM-IV diagnostic criteria might account in part for these much lower rates.

However, epidemiological studies show that lifetime rates of PTSD among children and young people are far lower than rates of exposure to traumatic stressors. Giaconia et al (1995) reported that nearly half of her sample of 18-year-old Americans had been exposed to trauma. In the Great Smoky Mountain Study, more than two-thirds of young people had experienced at least one traumatic event by the age of 16 years (Copeland et al, 2007). In Breslau et al (2007), 75% of teenagers reported having experienced trauma

by the age of 16 years. In other words, at a community level, most children exposed to trauma do not develop PTSD. This implies that trauma exposure alone is insufficient to explain the development of PTSD.

1.5 RISK FACTORS

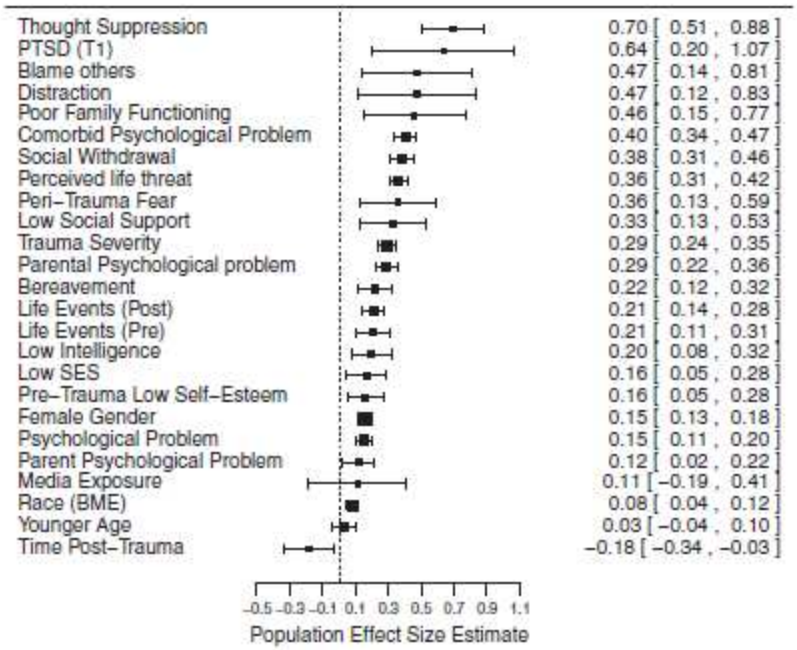
Many children who are exposed to traumatic events do not develop PTSD. Most research on PTSD in childhood recognises that a wide range of different factors are associated with risk of developing chronic PTSD in children.

There is some evidence that trauma severity (Pynoos et al, 1993; Foy et al, 1996; Pine & Cohen, 2002; Giannopolou et al, 2006), trauma type (Copeland et al, 2007), and, at an individual level, gender (with females being at higher risk than males; Pine & Cohen, 2002; Hampel & Petermann, 2005; Copeland et al, 2007), age (with adolescents being at higher risk than younger children; Green, 1991; Foy et al, 1996; Salmon & Bryant, 2002), prior behavioural difficulties (e.g. difficult temperament, antisocial characteristics, and hyperactivity; Breslau et al, 2006; Koenen et al, Moffitt, 2007) and a pre-trauma history of psychological difficulties, especially anxiety problems (Breslau et al, 2006; Copeland et al, 2007; La Greca et al, 1998; Udwin et al, 2000; Weems et al, 2007) and depression (Lengua et al, 2005) can increase the likelihood that a child will develop PTSD. However, these personal vulnerability factors and objective trauma severity indicators explain only a modest proportion of the variability in children's reaction after trauma. In other words, knowledge of these factors would only go so far in helping to predict which individuals go on to develop chronic PTSD (Ozer et al, 2003; Trickey et al 2012).

As shown in Table 1, a recent meta-analysis (Trickey et al, 2012) estimated the population effect sizes of 25 potential risk factors for PTSD in children and adolescents aged 6–18 years across 64 studies (N = 32,238) and identified the following categories: demographic factors, pre-trauma factors, objective trauma characteristics, subjective trauma characteristics, post-trauma individual factors, post-trauma psychological environment. Pre-trauma variables and more objective measures of the assumed severity of the event generated small to medium effect sizes, whereas medium to large effect sizes were shown for many factors relating to subjective experience of the event (peri-trauma fear, perceived life threat) and post-trauma variables (low social support, social withdrawal, comorbid psychological problem, poor family functioning). The findings

also supported the cognitive model of PTSD as a way of understanding its development and guiding interventions to reduce symptoms (Ehlers and Clark, 2000).

Table 1: Forest plot of all risk factors, showing their population effect size estimate, their confidence interval and the range of effect sizes from different studies. Source: Trickey et al, 2012



Subjective trauma characteristics (i.e. the perception of threat and peri-traumatic affect; Perrin et al, 2000; Winston et al, 2003), and post-trauma factors, for example parental reaction to the trauma and psychological environment, are associated with risk of developing chronic PTSD in children (Pine & Cohen, 2002; Pynoos et al, 1999; Copeland et al, 2007). Pine and Cohen's 2002 review found that in addition to trauma exposure, levels of social support were consistently associated with mental health outcomes for children exposed to a potentially traumatic event. Furthermore, Pynoos and colleagues (1999) suggested that child-extrinsic factors such as parental and family functioning may be associated with a child's vulnerability by moderating the impact of the event, the impact of proximal reminders and the impact of secondary stresses, such as an adverse family environment, indexed by coming from an impoverished or poorly educated home (Copeland et al, 2007). This indicates that subjective peri-trauma factors and post-event factors and psychological environment are likely to have a major role in determining whether a child develops PTSD following exposure to a traumatic event. Such factors could potentially be assessed following a potentially traumatic event in

order to screen for those most vulnerable to developing PTSD and target treatment efforts accordingly.

1.6 THEORETICAL MODELS OF PTSD

As described previously, there is a large overlap in the PTSD symptoms seen in adults and children. Therefore theoretical models developed to account for the development and maintenance of PTSD in adults can also be helpful in understanding PTSD in children (Meiser-Stedman, 2002). There are various different theoretical views on the development of PTSD, both behavioural (Keane et al, 1985) and cognitive (Brewin et al, 1996; Ehlers & Clark, 2000).

1.6.1 BEHAVIOURAL MODELS OF PTSD

Keane et al (1985) used classical and operant conditiong principles to explain the development and maintenance of PTSD. The authors proposed that neutral stimuli, occurring during the traumatic event, become conditioned to elicit the same responses (e.g. fear, startle, arousal, vigilance) as the unconditioned trauma stimuli. Other stimuli that either closely resemble or become paired with the traumatically-conditioned stimuli also trigger fear responses (stimulus generalisation). In behavioural models of fear acquisition, links between conditioned stimuli and the unconditioned stimulus/response network are represented in memory, so that the conditioned stimuli can elicit fear responses and memories of the conditioning experience (e.g. Bouton & Nelson, 1998). Keane et al's 1985 model suggests that avoidance is the factor by which the conditioned links between stimuli and fear responses are maintained. Avoidance can be both behavioural (i.e. avoidance of reminders of the trauma, like situations, people, places, etc) and cognitive (i.e avoidance of the traumatic memories to reduce or stop the conditioned fear response). This way, avoidance prevents extinction of the fear response, and therefore the PTSD symptoms are maintained. As suggested by Keane et al (1985), this phenomenon could possibly be enhanced, unknowingly, from people around the traumatised individual who discourage talking about the traumatic event, thus actively preventing contact with the fear eliciting stimuli, blocking the extinction process and, again, maintaining the PTSD symptoms.

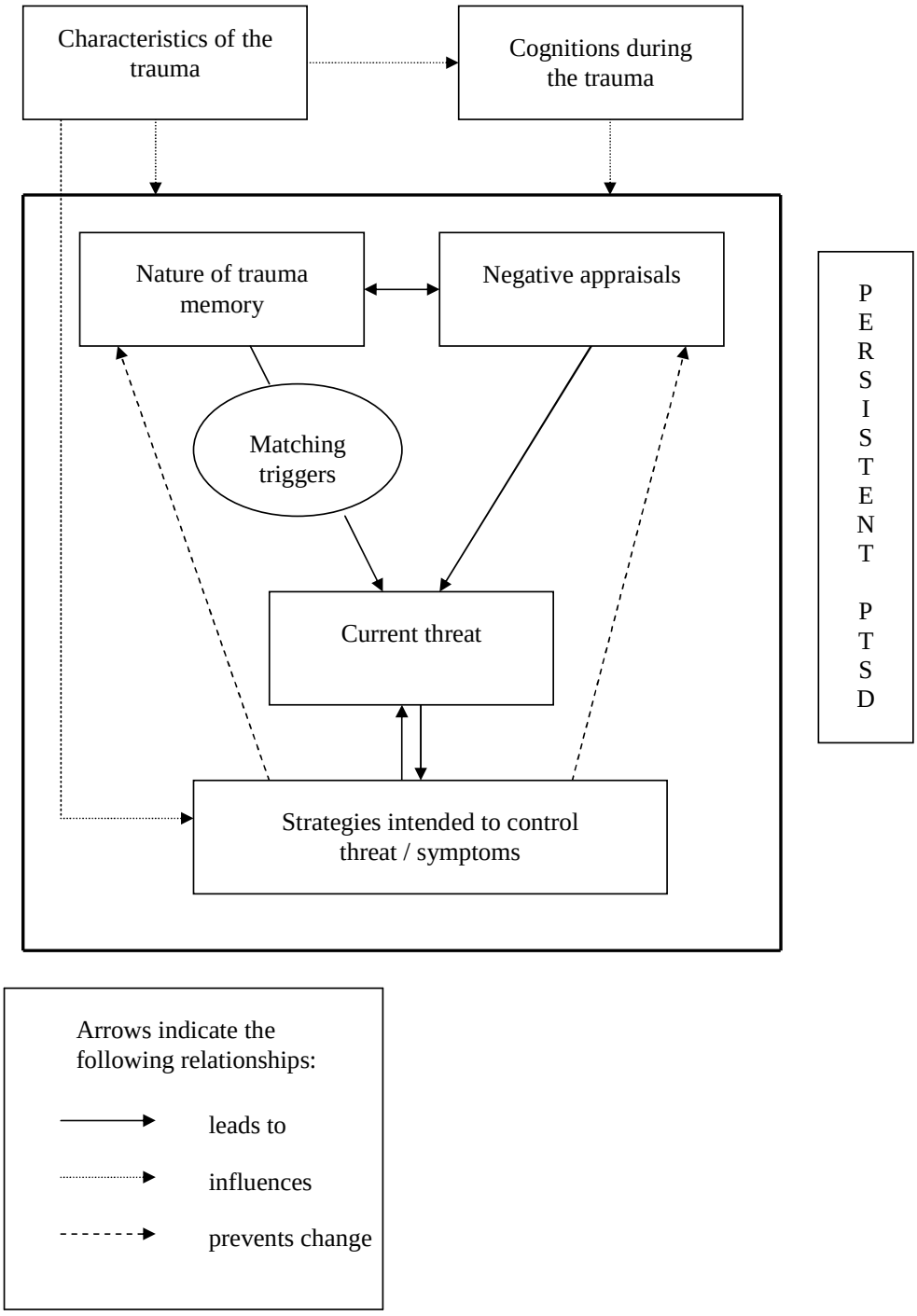
1.6.2 COGNITIVE MODELS OF PTSD

Brewin et al's (1996) dual-representation model also explains how PTSD symptoms are maintained by appraisals of the trauma that cause secondary emotional reactions (e.g.

sadness, guilt, shame, anger) which often interfere with the emotional processing of the event. In this way the emotional responses associated with the trauma continue to trigger the 'situationally accessible memories' (i.e. directly triggered by sensory stimuli associated with the event) and may even reinforce them. Avoidance (both behavioural and cognitive) also provides an explanation for how PTSD symptoms may become persistent: by actively avoiding the trauma reminders and thoughts about the events, the trauma memory is prevented from being elaborated into the 'verbally accessible knowledge store' (i.e. consciously through meaning-based strategies).

The cognitive model proposed by Ehlers and Clark (2000), which is represented in Figure 1, builds on the dual-representation model (Brewin et al, 1996) and highlights the primary cognitive factors underlying the development and persistence of PTSD. This model seeks to explain how a sense of serious current threat persists in people with PTSD, despite the traumatic event having happened in the past. This is thought to arise due to the: (i) idiosyncratic misappraisals about the trauma and/or its sequelae, and (ii) nature of the trauma memory. Misappraisals about the event itself or its consequences may take the form of over-generalisation of danger and lead to a sense of inflated responsibility and excessive guilt. Ehlers and Clark (2000) propose that in PTSD trauma memories are disjointed, sensory-based and poorly elaborated, and so inadequately integrated into autobiographical memory. This leaves them vulnerable to being accidentally triggered by sensory details associated with the trauma. This poor elaboration of trauma memories helps to explain the poor intentional recall of traumatic material, the frequent intrusive memories of the trauma and the sense of 'nowness' accompanying such unwanted memories. Both the misappraisals about the trauma and the nature of the trauma memory, lead to a range of unhelpful cognitive and behavioural coping strategies (e.g. avoidance), which have the unintended effect of increasing rumination and preventing from engaging with sources of support or pleasurable activities. The combination of these symptoms results in a general sense of distress, which in turn increases sense of current threat (Ehlers & Clark, 2000).

FIGURE 1: THE COGNITIVE MODEL OF PTSD (Ehlers & Clark, 2000)



Both the behavioural and cognitive models emphasise the importance of avoidance in the maintenance of PTSD and thus therapeutic exposure plays a central role in both cognitive and behavioural treatments for PTSD. However, the cognitive models highlight the role of negative appraisals in the development and persistence of PTSD and thus the importance of cognitive restructuring during exposure exercises as a way of challenging individuals' problematic appraisals associated with the trauma to bring about recovery (e.g. Ehlers et al, 2005).

1.6.3 COGNITIVE MODELS AND CHILDREN

The Ehlers and Clark (2000) model was specifically developed to account for PTSD in adults, rather than children. Adaptations of the model take into account the age and development of the child, such as language abilities, memory encoding and retrieval, and emotion regulation (Meiser-Stedman, 2002; Salmon & Bryant, 2002; Bolton, 2004). Recent research, however, indicates that the cognitive model can also be applied to children with PTSD (Udwin et al, 2000; Ehlers et al, 2003; Stallard, 2003, 2006; Bryant et al, 2007; Meiser-Stedman et al, 2007; Salmon et al, 2007; Stallard & Smith, 2007; Smith et al, 2007; Meiser-Stedman et al, 2009). There is empirical evidence that the three factors specified by the Ehlers and Clark (2000) adult cognitive model (i.e. negative appraisals, nature of trauma memory and unhelpful coping strategies), predict chronic PTSD in children and young people.

First, there is growing evidence that negative appraisals play an important role in the maintenance of PTSD in children. For example, Stallard and Smith (2007) found that negative appraisals about subjective threat and interpretation of symptoms accounted for 60% of the variance in symptoms' severity among children who had been assessed eight months after a RTA. Similarly, Salmon et al (2007) found that in young children hospitalised after traumatic injury, negative appraisals measured by the Child Post Traumatic Cognitions Inventory (cPTCI, Meiser-Stedman et al, 2009) accounted for 44% of the variance in acute stress disorder (ASD) symptoms. In addition, negative appraisals about future harm accounted for the majority of the variance in ASD symptoms, at six months follow up post trauma (Bryant et al, 2007). Two prospective studies (Ehlers et al, 2003; and Meiser-Stedman et al, 2007) also reported consistent findings.

Second, there is now emerging evidence that shows that the nature of trauma memory is also related to PTSD symptoms in children. Meiser-Stedman et al (2007) found that, the presence of more sensory-based memories assessed via the Trauma Memory Quality Questionaire (TMQQ, Meiser-Stedman et al, 2007), was related to symptoms at six months post trauma in children who had attended hospital accident and emergency departments following road traffic accidents or assaults. Similarly, Salmond et al (2011) found that in young people who sought emergency medical attention following an assault or RTA, trauma narratives had significantly higher sensory content and significantly lower positive emotion content compared to unpleasant comparative narrative, and that the ones with ASD had significantly elevated levels of disorganisation in their trauma narrative, compared to trauma-exposed controls. This work requires replication (e.g. see Stallard & Smith 2007 for negative findings) and extension to younger samples, but appears promising.

Third, there is evidence that unhelpful coping strategies (e.g. avoidance) also maintain PTSD symptoms, from both prospective (Stallard 2003; Meiser-Stedman et al, 2009) and retrospective (Udwin et al, 2000) studies with children.

Fourth, parent-child interactions and family factors, such as parental symptomatology, reactions and coping strategies, play an important role in the maintenance of children's PTSD (Salmon & Bryant, 2002; Meiser-Stedman et al, 2006; Smith et al, 2007). It is important to consider the impact of external influences (parental attitudes, appraisals and behaviour) on the child's cognitive processes when applying the cognitive model of PTSD to the assessment and treatment of children, especially as maintaining factors in PTSD. As found in previous literature on other childhood anxiety disorders, it seems likely that specific parenting behaviours and attitudes (as well as potentially the parent's trauma-related appraisals) will be associated with the levels of distress and anxiety in children suffering from PTSD; however, there has been no research of this nature conducted so far and family factors in childhood PTSD have received relatively little attention to date. Previous findings showed that: (i) parental psychological difficulties co-vary with the child's, however with small to medium effect sizes, and (ii) poor family functioning appears to have a stronger effect; the former construct being the more established correlate of PTSD (being examined in 25 studies), and the latter being adequately addressed only in 4 studies (Trickey et al, 2012). The current study will aim to test both aspects, with more emphasis on the latter, where it is needed.

1.7 SUMMARY OF PART A

PTSD occurs in children and adolescents as frequently as it does in adults after a trauma. Models originally proposed to explain how PTSD develops and is maintained in adults have been adapted for use in children. These factors specified in the model focus primarily on intra-psychic phenomena (conditioning, memory/emotional processing, and negative appraisals) and the behaviour of the traumatised individual (i.e. avoidance). However, and while limited, there is evidence to suggest that parents and other family members may influence the duration and severity of PTSD in children. In the next section this literature will be summarised.

PART B: PARENTAL FACTORS AND FAMILY FUNCTIONING RELATING TO CHILD PTSD

As discussed previously, a recent meta-analysis (Trickey et al, 2012) indicated a relationship between what happens after the traumatic event (called the 'post-trauma psychological environment') and the development of PTSD. All the risk factors considered (for example, parental psychological difficulties including PTSD, lack of social support, poor family functioning, and a family environment characterised by a lack of cohesion and expressiveness) showed small to medium or large effect sizes and were assumed to contribute to ongoing symptomatology (Wickrama et al, 2007; Green et al, 1991; Korol et al, 1999; McFarlane 1987; Kilic et al, 2003; Pullins et al, 2005; Swenson et al, 1996; Vijayakumar et al, 2006). Parental psychological difficulties showed small to medium effect sizes whilst low social support, family poor functioning and social withdrawal showed medium to large effect sizes. Whilst social support has been identified as being a factor of potential great importance to the successful resolution of traumatic experience in adults (e.g. Davis & Siegel, 2000; Pine & Cohen, 2002), Trickey et al's (2012) meta-analysis only found 4 studies that have adequately addressed this construct. Poor family functioning was a stronger risk factor for PTSD than poor parental mental health, though parental mental health is the more established correlate of PTSD (being examined in 25 studies), and its effect size was on the borderline between a medium and a large effect size.

1.8 PARENTAL PSYCHOPATHOLOGY

In general, parent psychopathology increases the risk of child psychopathology development (Tiet et al, 1998). When specifically assessing PTSD symptom

relationships in parents and children, studies have reported contrasting findings; some have shown a significant relationship (e.g. McFarlane, 1987; Swenson et al, 1996; Green, 1991; De Vries et al, 1999; Jensen et al, 1999; Laor, 2001), while others have not suggested that a relationship exists (e.g. Landolt et al, 2003).

Available evidence suggests that maternal symptoms of PTSD and depression are related to child PTSD symptoms across a variety of settings and populations (e.g. Wolmer et al, 2000; Smith et al, 2001; Meiser-Stedman et al, 2006). Studies of children involved in natural disasters have found maternal mental health to be a stronger predictor of children's post-traumatic stress symptoms than exposure to the traumatic event but only when relying on maternal report for the child's PTSD symptoms (McFarlane, 1987; Swenson et al, 1996). Similarly, two studies of war-exposed children have found that maternal reported distress was the best predictor of maternal reported PTSD symptoms in their child (Bryce et al, 1989; Dawes et al, 1989). However, when relying upon both maternal and child-reports of the child's PTSD, Smith et al (2001) found that war-exposure was the best-predictor of the child's PTSD and anxiety, however maternal mental health significantly added to this effect. Interestingly, mother's reports of their child's PTSD / anxiety were mediated by the severity of their own trauma reactions.

A recent study found that parental worry and depression acted as mediators for the experience of trauma and PTSD symptoms in children and adolescents (Meiser-Stedman et al, 2006). Meiser-Stedman and colleagues (2006) found that parental endorsement of worry as a helpful strategy appeared to mediate the relationship between maternal depression and child PTSD. Further research is needed, but evidence to date implies that psychopathology and cognitive styles within the family play a significant role in maintaining children's PTSD.

Symptoms displayed by symptomatic family members can also increase the risk for secondary traumatisation for children or other family members (Kilic et al, 2003). Specifically, Kilic et al (2003) demonstrated that exposure to fathers afflicted with PTSD and depression, who displayed irritability and detachment, had the potential to moderate the severity of PTSD in children (Kilic et al., 2003). Studies have also shown children's PTSD symptoms to be related to their mother's symptoms (e.g., Jarvi et al, 2005; Rossman et al, 1997). For example, Chemtob and Carlson (2004) reported that

mothers' PTSD caused them to be more reactive and impulsive when interacting with their children, which in turn created the child's behavioral problems and decreased family functioning. In addition, Self-Brown et al (2006) found that adolescents of parents with higher global psychological distress levels were experiencing higher levels of PTSD and depression. Specifically, they reported parental mental health as being strongly related to adolescent's PTSD symptomatology. Parents suffering from PTSD may model PTSD symptoms such as avoidance or hyperarousal behavior. In addition, they may overlook their children's anxieties or symptoms because they are preoccupied and overwhelmed by their own symptoms. Consequently, they may engage in poor parenting styles, which further exacerbate their children's symptoms.

1.9 FAMILY POST-TRAUMA COMMUNICATION

Parents of traumatised children could play a role in maintaining their symptoms, for example, by helding beliefs about the potential consequences of talking about the trauma, and therefore positively reinforcing the child's avoidance of discussion, modelling avoidance, or actively removing the child from contact with trauma reminders. However, the effect of trauma on the communication between mothers and their children is likely to be bidirectional. One possibility is that children and carers negatively reinforce each other for avoiding discussion of the trauma. Meiser-Stedman et al (2006) and Smith et al (2007) suggest that children and their parents may both avoid talking about the traumatic event for fear of upsetting each other. Both may verbalise and model dysfunctional trauma-related beliefs and safety seeking behaviours. That is, parents and children may get locked into cycles of avoidance, each maintaining the other's maladaptive beliefs and coping strategies. This poor family post-trauma communication may interfere with the processing of the traumatic memory, reinforce avoidance, and help to strengthen trauma-related beliefs – all of which help to maintain PTSD symptoms in both the parent and child. To date, there are no published studies measuring the communication between parents and children post-trauma to see if this contributes to PTSD maintenance or severity.

1.10 FAMILY ENVIRONMENT

In general, families that lack support, independence, and social integration, and are characterised by conflict and control (as measured by the Family Environment Scale, FES; Moos & Moos, 1994) are more likely to have children with a range of different emotional difficulties, including anxiety and depression (Williams et al, 1990). In this

respect, Pryor and Woodward (1996) found that low family cohesion and expressiveness and high conflict (as measured by the FES) when children were aged 7 and 9 predicted a higher likelihood of children having emotional or behavioral difficulties at age 15. On the other hand, in an Indian study (Malhi & Singh, 2003) more family expressiveness and less family control were associated with better emotional and behavioral functioning among children who had a conversion disorder.

The family environments of children with anxiety disorders, including PTSD, have been found to be more structured (focusing on achievement, moral-religious emphasis, and organisation), higher in conflict, and less cohesive, expressive, and independence-oriented (as measured by the FES). Mothers of children with anxiety disorders may discourage emotional discussion and establish a climate of inhibited emotional expression (Halloran et al, 2002; Linning & Kearney, 2004; Overstreet & Braun, 2000; Suveg et al, 2005). Among adolescents hospitalised for treatment of psychiatric disorders, those who experienced their families as higher on conflict and less cohesive and expressive tended to report more trauma-related symptoms, anxiety, dissociation, and depression (Sadowski & Friedrich, 2000).

1.10.1 FAMILY COHESION

The relationship between family cohesion and PTSD symptoms among child victims of traumatic events has frequently been the object of research (Cohen et al, 2000). Generally, empirical studies showed that higher levels of family cohesion are associated with lower levels of PTSD. The positive role of parental support for children's coping was also found in investigations of natural disasters (e.g. La Greca et al, 1996; Prinstein et al, 1996; Vernberg et al, 1996). Furthermore, the participation of the family in the treatment process following a traumatic event or stressor is considered key to recovery. For example, a family atmosphere characterised by new and ongoing stressors has been associated with decreased treatment benefits for individuals suffering from PTSD (Tarrier et al, 1999). In other words, the lack of family cohesion (or its presence) predicts children's symptoms irrespectively of trauma exposure. Thus, parental love, care, and attention are important and beneficial for trauma survivors.

1.10.2 FAMILY CONFLICT

An additional family factor that might moderate the relationship between trauma exposure and PTSD symptomatology may be the level of conflict within the family (e.g.

Constantine, 2006). A home atmosphere with arguments and conflicts may be perceived by children and young people, who have been exposed to traumatic events, as an indication of lack of family support. Research on negative responses of support providers, such as engaging in arguments, blaming or showing disinterest responses at times referred to as 'negative social support' (e.g. La Gaipa, 1990), strongly documented their potential to impede recovery from all traumas (Kaniasty, 2005; Kliewer et al, 1998; Lepore et al, 1996). Studies showed that an increase in the number of conflicts and arguments may be observed within families experiencing traumas because of excessive burdens and responsibilities in many areas of life (Gleser et al, 1981; Hutchins & Norris, 1998). A link between conflicts at home and levels of PTSD symptoms was established by Wasserstein and La Greca (1998). Gleser et al (1981) also provided empirical evidence for the connection between the atmosphere prevailing in a family and the children's well-being. Children from families affected by traumatic events or stressors, where an atmosphere of conflict and irritation was present to a greater extent, showed more symptoms of distress than children from families where a peaceful atmosphere predominated. Similarly as with (lack of) social support, the intensity of family conflicts influences the levels of PTSD symptoms directly and independently of the levels of trauma exposure. Most likely, lack of family warmth, support, and conflicted home atmosphere are generally detrimental to a young person's well-being when faced with a longer coping with trauma.

1.10.3 PARENTAL OVER-PROTECTIVENESS

Another family factor discussed in the literature as a potential predictor of adolescent's well-being following the experience of traumatic events is parental over-protectiveness. Parental over-protectiveness could be conceptualised as another manifestation of liabilities of parental social support because it involves excessive and unnecessary parental protection that is uncalled for given the child's developmental stage. In a review of the literature, Holmbeck et al (2002) characterised parental over-protectiveness as a tendency for infantilisation, toward excessive physical and social contact with a child, extreme fear associated with the fulfilling of parental functions, unwarranted control, intrusiveness, and continuous attempts at impeding the child's independence. The most exemplary investigation of parental over-protectiveness in the context of disasters is McFarlane's (1987) bushfire study. He observed that parental over-protectiveness constituted a risk factor for the development of PTSD symptoms in children and attributed this parental attitude to fears about the family's safety should

such a tragedy recur. Similarly, Henry et al (2004), in a more recent examination, showed an increase in parental monitoring in the aftermath of the September 11th terrorist attacks. Parental over-protectiveness, manifested as a strong need for tight supervision of children, has been interpreted as a reaction to the threat of further attacks. Therefore, excessive parental control and infantilisation of children, in combination with higher levels of exposure to trauma, were associated with higher levels of PTSD symptoms among children and young people exposed to trauma.

1.10.4 FAMILY ENVIRONMENT AND PTSD

General family functioning and atmosphere (characterised by 'irritable distress' but not by 'involvement' and 'over-protection') has been found to relate to children's PTSD symptoms (McFarlane, 1987), but this finding requires replication. Green (1991) showed that an irritable and/or depressed family atmosphere and maternal psychopathology contributed to the prediction of PTSD symptomatology in the children. Laor et al (2001) assessed the long-term consequences of the SCUD missile attack in Israel on children as a function of their mothers' psychological functioning, family cohesion, and the event itself, and found that greater severity of symptoms was associated with being displaced, living in a family with inadequate cohesion, and having a mother with poor psychological functioning. Despite a continuous decrease in symptom severity, risk factors identified shortly after the Gulf War continued to exert their influence on children 5 years after the traumatic exposure. In Wickrama and Kaspar (2007) measures of family functioning (family and social-community loss, and mother-child relationship) were associated with PTSD symptoms in adolescents exposed to the Tsunami. Jensen et al (2009) investigated the prevalence of PTSD symptoms and factors related to level of these in children aged 6 to 17 who experienced a catastrophe as tourists (the 2004 Tsunami) and were therefore able to return to the safety of their homeland. They found a relationship between parental mental health and children's PTSD scores at follow-up, indicating that parental distress may contribute to the maintenance of children's PTSD. However, the family environment, measured with the two subscales of 'cohesion' and 'expressiveness' from the FES, was not independently related to the children's PTSD scores. Otto et al 2007 investigated the effects of indirect trauma exposure, the media viewing of tragic events (September 11th 2001) on 166 children and 84 mothers. Family environment was assessed at entry into the longitudinal study for each mother and child using the FES. The FES Conflict and Cohesiveness dimensions were not related to full or subsyndromal PTSD symptoms

measured by the K-SADS and IES-R. However, family Expressiveness was significantly associated with lower risk of full or subsyndromal PTSD symptoms, as well as lower ratings of PTSD symptoms on the IES-R.

1.11 EVIDENCE OF FAMILIAL INFLUENCE FROM FAMILY INTERVENTIONS

Where appropriate, families should be involved in the treatment of PTSD in children and young people. The value of including families in treatment comes across strongly, to support the person with PTSD and their families, especially if the trauma affects other family members. Generally, recommendations are to provide support to families as well as helping families to support the person who has PTSD, particularly when the families underestimate the impact of trauma in children. However, treatment programmes for PTSD in children and young people that consist of parental involvement alone are unlikely to be of any benefit for PTSD symptoms. When considering treatments for PTSD, parents and, where appropriate, children and young people should be informed that, apart from trauma-focused cognitive-behavioural therapy (NICE Guidelines, 2005), there is at present no good evidence for the efficacy of widely-used forms of treatment of PTSD such as play therapy, art therapy or family therapy (Ramchandani & Jones, 2003). Cohen and Mannarino (2006) evaluated different family treatments, for example Multisystemic Therapy (Brunk et al, 1987) and Multifamily Group Therapy (MFGT) (Meezen & O'Keefe, 1998a, 1998b), focused on improving parent-child interactions along with parent training. However, these systemic programs were for families with children who had been abused and neglected. The evidence base showed that both treatments reduced psychiatric symptoms, reduced stress, and improved individual and family problems, with Multisystemic Therapy showing greater amelioration than Parent Training in most areas. The families engaged in MFGT showed significantly more positive changes in family functioning, children reported more assertiveness and less submissiveness and caregivers reported fewer behavioral problems including aggressiveness (compared to families receiving traditional family therapy).

1.12 SUMMARY OF PART B

Parental and family functioning have been identified as potential risk factors for the development and maintenance of PTSD in children. The clinical implication of these findings suggests that the potential role of parents needs to be considered when working with children, particularly with regard to maintenance of PTSD symptoms. Given that

research findings have been mixed, determining additional factors affecting children exposed to trauma is important.

PART C: EXPRESSED EMOTION (EE)

1.13 PARENTING FACTORS IN CHILD ANXIETY DISORDERS

As described in section B, a range of parenting factors are likely to be relevant to the development and maintenance of PTSD symptoms in children. However the majority of research in the broader area of childhood anxiety has focused on the two broad dimensions of criticism and over-involvement (Bögels & Brechman-Toussaint, 2006). The dimension of parental criticism has generally been conceptualised as including criticism, negativity and rejection (e.g. Rapee, 1997; Wood et al, 2003), contributing to a child's belief that their environment is hostile or threatening (Bögels & Tarrier, 2004; Krohne & Hock, 1991) and increasing a child's sense of uncertainty about their skills or undermining a child's emotional regulation by inducing or reinforcing feelings of insecurity (McLeod et al, 2007). The dimension of parental over-involvement includes over-involvement, over-control and over-protection (McLeod et al, 2007; Wood et al, 2003), is characterised by excessive regulation of a child's activities or routines, high levels of parental vigilance and intrusion, and the discouragement of independent problem solving. These behaviours may restrict a child's opportunities to develop confidence in dealing with challenging situations and may convey to the child that the environment is uncontrollable or too dangerous for them to cope with on their own (Bögels & Brechman-Toussaint, 2006). Parental over-involvement may also reinforce a child's avoidant responses to challenging situations and limit the development of a child's autonomy, competence and mastery (Chorpita & Barlow, 1998; Hudson & Rapee, 2004; Wood, 2006). This is thought to have the effect of decreasing a child's self-efficacy and therefore increasing their anxiety.

1.14 EXPRESSED EMOTION (EE)

The parenting constructs described above as relevant to childhood anxiety disorders are highly similar to the concept of EE, which refers to a family interaction style characterised by hostility, criticism and emotional over-involvement (Vaughn & Leff, 1976).

The construct of EE is now well established as an important measure of the emotional climate between the respondent and their relative and of the family environment. Developed in the 1960s and 1970s by Brown et al (1966, 1972), EE is a concept used to define the overt expression and quality of the emotions expressed by carers, close family members and significant others of clients, and was originally conceptualised in for use with families of people with psychosis (Brown et al, 1958; Leff & Vaughn, 1985). It was suggested that the quality of the relationship between the relative and the client might be related to their subsequent outcome. It was assumed that clients who lived with a family member/loved one/carer who behaved in a critical, hostile, or over-involved manner would result in chronic and accumulating stress and poorer treatment outcomes for psychosis (Kavanagh, 1992; Bebbington & Kuipers, 1994; Butzlaff & Hooley, 1998).

1.15 PREVIOUS RESEARCH ON EXPRESSED EMOTION (EE)

The concept of EE has been widely used in research in the psychosis field since the early studies of Brown and colleagues (Bebbington & Kuipers, 1994; Vaughn & Leff, 1976) and has led to the development of treatment programs incorporating the family, which have been seen to reduce relapse rates in this clinical population (Leff et al, 1990; Bebbington & Kuipers, 1994; Butzlaff & Hooley, 1998).

Although the vast majority of studies employing EE measures have been carried out in relation to course and outcome of psychosis, there is an emerging view that EE may also influence the course and outcome of a wide range of health and mental health conditions (Wearden et al, 2000). High EE has been linked to increased relapse rates in eating disorders (Butzlaff & Hooley, 1998), depression (Hooley, 1986; Leff and Vaughn, 1985), bipolar disorder (Miklowitz et al, 1988), substance abuse (O'Farrell et al, 1998), anxiety disorders (Chambless & Steketee, 1999; Chambless, et al, 2001), and PTSD (Tarrier et al, 1999).

Similar findings have also been demonstrated in childhood disorders, with studies highlighting an association between high EE families and poorer outcomes in attention deficit hyperactivity disorder (Daley et al, 2003), depression (Asarnow et al, 2001), psychosis (Hamilton et al, 1999), oppositional defiant disorder (Nelson et al, 2003), self-injurious behaviour (Wedig & Nock, 2007) and anxiety (Stubbe et al, 1993).

1.16 MEASURES OF EXPRESSED EMOTION (EE)

The gold-standard measure of EE is a semistructured interview known as the Camberwell Family Interview (CFI; Leff & Vaughn, 1985). The CFI is conducted with the client's key relatives (typically parents or a spouse) without the client being present and the interview is always recorded for later coding. Questions address the onset of the client's disorder and the symptoms that were apparent to the relative in the months prior to the client's hospitalisation or exacerbation of illness. Also discussed are the level of tension in the household, irritability, participation of the client in routine household tasks, and the daily routines of the client and various family members. The CFI is used to make ratings on five scales. These are Criticism, Hostility, Emotional Over-involvement (EOI), Warmth, and Positive Remarks. It is on the basis of the ratings on these scales that the classification of family members as high or low in EE is made. It is clear from the empirical literature that EE, measured with the CFI, is a construct with considerable concurrent and predictive validity (Hooley, 1986; Miklowitz et al, 1984). CFI-rated EE is also highly predictive of symptom relapse in clients with a wide variety of disorders (e.g. Butzlaff & Hooley, 1998; Chambless & Steketee, 1999; O'Farrell et al, 1998), and the predictive validity of the construct has been demonstrated cross-culturally (e.g. Phillips & Xiong, 1995; Tanaka et al, 1995).

However, the CFI can only be used by raters who have received between 40 and 80 hours of formal training, and training in rating EE is both expensive and difficult to obtain. In addition, the CFI is a lengthy measure which takes up to two hours to administer and another two to three hours to code. These factors combine to make the assessment of EE both costly and time consuming. In light of this, it is not surprising that there has been a great deal of interest in developing shorter, alternative measures of EE.

As a result, a shortened measure termed the Five Minute Speech Sample (FMSS, Magana et al, 1986) was developed. This has been found to correlate highly with the CFI in relation to classifying families as high or low EE (Halford, 1992). The FMSS is similar to the CFI in that family members are asked to speak about their thoughts and feelings about their relative. The FMSS, however, requires less time to administer (5 minutes) and score (20 minutes) compared with the CFI. Research has shown that the FMSS is reliable and that it provides ratings, which are comparable to those derived from the CFI (Magana et al, 1986). Studies investigating the utility of the FMSS have

applied the rating scheme to a variety of populations, including people with psychosis (Magana et al, 1986; Hawlhweg et al, 1989), bipolar (Miklowitz et al, 1988), head injury (Jacobs, 1990), children with attention deficit hyperactivity disorder (Marshall et al, 1990), children with depressive disorders (Asarnow et al, 1993), and Veterans Administration patients, and spouses of patients with Alzheimer's disease (Vitaliano et al, 1988, 1993). The FMSS is highly favored by researchers working with children and has been found to be correlated with mother–child attachment security (Jacobsen et al, 2000), maternal behavior (Daley et al, 2003), and child and adolescent behavior problems (Hirshfeld et al, 1997; Peris & Baker, 2000; Wamboldt et al, 2000).

1.17 EXPRESSED EMOTION (EE) AND ANXIETY DISORDERS

The FMSS has been utilised in the anxiety literature to examine the association between high EE and childhood anxiety disorders. Gar and Hudson (2008) examined EE using the FMSS and found that mothers of anxious children were more over-involved, over-protective and critical than mothers of non-anxious children. Hirschfield et al (1997) also reported a link between high EE and lifetime prevalence of developing an anxiety disorder. Few studies (Leonard et al, 1993; Hibbs et al, 1991; 1993) indicated that high levels of parental emotional over-involvement and criticism may contribute significantly to the onset and maintenance of OCD and disruptive-behaviour disorder, and may also decrease the likelihood of positive treatment outcomes influencing later functioning.

1.18 EE AND PTSD

In relation to PTSD, research examining EE is emerging, however only with adults. For example, Tarrier et al (1999) found that hostility and criticism within the family were significant predictors of PTSD symptomatology and that clients living, or having close contact, with a low EE relative showed significantly greater improvement over treatment than clients with a high EE relative. The hostility and criticism variables were significant predictors of the comprehensive measure of PTSD symptomatology. Thus, the quality of the relationship between the client and their relative appeared to have a significant effect on the client's response to treatment.

Another study (Barrowclough et al, 2008) investigated the relationship between EE, causal attributions in relatives of PTSD clients, and client outcomes. Criticism and hostility in relatives were associated with attributing problems to factors controllable by

clients. Relatives with marked emotional over-involvement (EOI) had an attributional profile similar to low EE relatives. Deficits in normal behaviour ('negative symptoms') were perceived as more controllable, internal and stable than were more obvious signs of an illness or mental health problem such as hypervigilance and intrusive thoughts and nightmares ('positive symptoms'). Irritability and anger were perceived as more controllable and personal than any other problem. Hostility was associated with less psychological understanding. EE (hostility) but not attributions was found to predict clinical outcome. The study suggested a need for interventions, which focus on helping relatives to reappraise the impact of PTSD.

One study (Hetterscheidt, 2008) examined the association between both positive and negative parental EE (as coded from the Five Minute Speech Sample) and outcomes (PTSD symptoms, depression, anxiety, suicide) among child victims of sexual abuse. Analyses found no relationship between EE and outcome measures neither at initial assessment, nor at the follow-up assessment. It was noted, however, that child reported symptoms decreased over time. It was found that as positive affect percentage increased, parent and child report of symptoms decreased. The relationship between positive affect percentage and mental health outcomes among child victims of sexual abuse may offer a target for intervention. Getting parents to think and speak more positively about their child and their emotions toward their child may help buffer against the negative impact from the sexual abuse experience and is an area that requires further research.

In the absence of additional data on EE and PTSD there are compelling reasons why research examining EE in the families of traumatised children may be warranted:

- The presence of a traumatised individual in the family can have significant emotional and mental health impacts on the wider family (Solomon et al, 1987; Verbosky & Ryan, 1988; Jordon et al, 1992; Riggs et al, 1998);
- Psychiatric morbidity in traumatised populations is predicted by family instability and quality of relationship with the partner (Romans et al, 1995; King et al, 1996);
- High EE relatives are more likely than low EE relatives to behave in a more intrusive and negative way towards family members who have mental health problems (Strachan et al, 1986a, b; Hahlweg et al, 1989);

- The presence of a high EE relative in the home is associated with elevated levels of autonomic arousal in the client (Tarrier et al, 1979, 1988; Tarrier & Turpin, 1992) and hyperarousal is one of the three cardinal symptoms of PTSD;
- Client's perceptions of the availability of emotional and physical (tangible) social supports are significantly and negatively correlated with their PTSD symptoms (Green et al, 1985; Keane et al, 1985);
- Clinical reports that demonstrate the benefit to traumatised veterans of including their families in treatment (Figley, 1990; Rabin & Nardi, 1991; Glynn et al, 1995);
- A body of evidence suggesting that parental over-control and a lack of warmth towards the child are associated with higher rates of anxiety and depression in the child (Whaley et al, 1999; Wood et al, 2003).

1.19 SUMMARY OF PART C

EE is a measure of family environment and is viewed as a valid indicator of the way families interact around difficult topics/stressors and is increasingly used in research looking at parental effects on child anxiety more broadly. EE is of interest to researchers and clinicians because it predicts symptom relapse in clients and because family-based interventions that seek to reduce EE have had success in decreasing clients' relapse rates (Hogarty et al, 1986; Leff et al, 1982). In relation to PTSD, research examining EE is emerging, however only with adults.

PART D: THE PRESENT STUDY

1.20 RATIONALE

The purpose of the present study is to add to the existing literature by looking at family factors and their relation to post-traumatic responding in the child. This will be accomplished by measuring child and parent symptomatology, family post-trauma communication, family environment, and EE.

The present study is exploratory in nature and aims to advance our understanding of how family factors might influence the symptomatology of children aged 7 to 18 clinically referred for PTSD following a traumatic event. Given that research findings have been mixed, determining additional factors affecting children exposed to trauma was important.

The study's primary aim was to explore the potential associations between parental and family functioning with child PTSD symptomatology, by establish whether parental expressed emotion (particularly criticism and over-involvement), family environment, family post-trauma communication, and parent symptomatology were related to child symptomatology.

1.21 METHODOLOGICAL CONSIDERATIONS

To assess family post-trauma communication and the parent and child's willingness to talk to each other about the trauma and their feelings, a new additional measure needed to be developed and tested, which was named the Talking About Trauma Questionnaire. This measure, specific to the trauma aftermath and atmosphere within the family, assessed whether the effects of the traumatic event on the interaction between parents and children was bidirectional, for example by children and parents negatively reinforcing each other for both avoiding talking about the traumatic event for fear of upsetting each other. These interactions may interfere with the processing of the traumatic memory, reinforce avoidance and vigilance, and help to strengthen trauma-related beliefs – all of which help to maintain PTSD symptoms in the mother and child.

To assess the role of family functioning in the maintenance of PTSD in children, the Family Environment Scale (FES; Moos & Moos, 1996) was used. The FES is composed of three sets of dimensions: relationship dimensions, personal growth (or goal orientation) dimensions, and system maintenance dimensions. The relationship and system maintenance dimensions primarily reflect internal family functioning, whereas the personal growth dimensions primarily reflect the linkages between the family and the larger social context. Specifically, the relationship dimensions are the following: (i) cohesion, which is the degree of commitment, help and support family members provide for one another, (ii) expressiveness, which is the extent to which family members are encouraged to express their feelings directly, and (iii) conflict, which is the amount of openly expressed anger and conflict among family members; the personal growth dimensions are the following: (iv) independence, which is the extent to which family members are assertive, are self-sufficient and make their own decisions, (v) achievement / orientation, which is how much activities (such as school and work) are cast into an achievement-oriented or competitive framework, (vi) intellectual-cultural orientation, which is the interest in political, intellectual, and cultural activities, (vii)

active-recreational orientation, which is the amount of participation in social and recreational activities, and (viii) moral-religious emphasis, which is the emphasis on ethical and religious issues and values; and finally, the system maintenance dimensions are the following: (ix) organisation, which is the degree of importance of clear organisation and structure in planning family activities and responsibilities, and (x) control, which is how much set rules and procedures are used to run family life.

1.22 RESEARCH HYPOTHESES

1) Parental EE, as measured by the Five Minutes Speech Sample (FMSS), will correlate moderately and significantly ($r = 0.4$, $p < .05$) with the child's self-reported PTSD as measured by the Child PTSD Symptom Scale (CPSS).

2) Family environment, as measured by the Family Environment Scale (FES), will correlate moderately and significantly ($r = 0.4$, $p < .05$) with the child's self-reported PTSD as measured by the CPSS.

3) Family post-trauma communication, as measured by the Talking About Trauma Questionnaire – child and parent versions (TATQ-C and TATQ-P), will correlate moderately and significantly ($r = 0.4$, $p < .05$) with the child's self-reported PTSD as measured by the CPSS.

4) Parental symptoms of PTSD, anxiety, and depression will be moderately and significantly ($r = 0.4$, $p < .05$) associated with the child's self-reported PTSD as measured by the CPSS.

1.23 SUMMARY OF PART D

The purpose of the present study is to add to the existing literature on parental factors relating to child PTSD, by looking at parental mental health and its relation to post-traumatic responding in both the mother and child. Particularly, as there has been very little research to date which has investigated family functioning in children and adolescents with PTSD, the current study aims to investigate whether parental expressed emotion, family environment, and family post-trauma communication are associated with childhood PTSD.

2. METHOD

2.1 DESIGN

The present study employed a cross-sectional, correlational design, using a clinical sample of children with symptoms of PTSD. This design involved correlating interview-based measures of parental EE and parent self-report measures of family environment, and measures of family post-trauma communication, with self-report questionnaire measures of child PTSD symptomatology.

2.2 PARTICIPANTS

2.2.1 SAMPLE SIZE

A power calculation was conducted using N-Query to determine the sample size needed to find moderate correlations between the independent and dependent variables. As no previous studies have examined parental EE and child PTSD symptoms, previous studies reporting correlations between self-report measures of parenting behaviour and child anxiety, and correlations between measures of parent and child anxiety were used as a guide to the power calculation.

Zabin & Melamed (1980) observed correlations of 0.29 to 0.59 between a parent self-report measure of parental responses to child anxiety (the Child Development Questionnaire - CDQ) and various self-report measures of child trait anxiety. Bogels and van Melick (2004) used a parent-report measure similar to the CDQ and found a correlation of 0.41 between parental reported over-protection and child reported anxiety. Based on these previous studies, it was considered reasonable that the relationships between the potential predictors and the child's PTSD symptoms would be in the moderate range. Assuming the current study would find moderate correlations of $r = 0.4$ at a significance level of $p = .05$, a sample size of 47 would provide 80% power to detect such correlations.

2.2.2 ETHICS AND RECRUITMENT

Ethical approval was given by the National Health Service Local Research Ethics Committee (The Joint South London and Maudsley NHS Foundation Trust & King's College London Ethics Committee) to recruit families from any child and adolescent mental health services within South London and Maudsley (SLaM) NHS Foundation

Trust (Ethics Ref no: 11/LO/0303 - Trust Approval R&D 2011/064, in Appendix 1). This included the community Child and Adolescent Mental Health Services (CAMHS) in Southwark, Lambeth, Lewisham, and Croydon, and from the the Child Traumatic Stress Service (CTSS) at the Maudsley Hospital. This latter service is a Tier 4 National and Specialist service that receives referrals from general practitioners (GPs) in primary care, as well as consultant psychiatrists and other mental health professionals from community CAMHS teams. Geographically, referrals to the CTSS can be made from any area of the country, although referrals come almost exclusively from the catchment area of SLaM. Families who had a child being assessed or treated for trauma related difficulties and met all of the inclusion criteria were recruited.

In order to recruit from the Child Traumatic Stress Clinic, the researcher was in regular contact with the clinicians within the team to be informed about current open PTSD cases and weekly referrals to screen for families suitable for the study. In addition, all possible efforts were made to recruit families from the community CAMHS teams. This included contacting the various teams, attending their team meetings in order to give a brief presentation about the project, provide information sheets to pass on to suitable families, and hand out information leaflets for staff (including details such as the study's inclusion criteria, the time frame of the study, how to contact the researcher about suitable families etc). In addition, further contact about recruitment was made to all team managers, in the form of sending information leaflets about the study, as well as regular monthly email reminders to check with staff about possible suitable referrals.

2.2.3 INCLUSION / EXCLUSION CRITERIA

The inclusion criteria were as follows:

- Children in the assessment or early treatment stages
- Children exposed to a specific traumatic event (regardless of whether parent was present)
- Children being referred for the treatment of a post-traumatic stress reaction (although DSM-IV diagnosis of PTSD did not need to be met to participate)
- Children attending the clinic with a parent
- Children aged 7-18 years
- At least one of the child's primary caregivers agreeing to participate in the study
- Parent and child both able to speak fluent English

In an attempt to reach the target sample size of 47, children who were in the middle to late stages of treatment were also included in the study. In total, 5 children were seen pre-intervention, 6 had just begun therapy (i.e. up to session number 5 of 12), and 11 were in the middle to later stage of treatment (i.e. from session number 6 onwards).

2.3 SELF-REPORT MEASURES

2.3.1 PARENT COMPLETED MEASURES

Post-Traumatic Stress Diagnostic Scale (PDS; Foa, 1995): The PDS was designed to assess PTSD (as defined by DSM-IV) in adults. It allows the clinician to assess whether sufficient symptoms are present to assign a PTSD diagnosis and provides a continuous score which measures PTSD severity. It has been demonstrated to have high internal consistency (r = .92) and good test-retest reliability (r = .74 for PTSD diagnosis and r = .83 for symptom severity) and it shows good agreement (r = .65) with the Structured Clinical Interview for DSM-IV (Foa et al, 1997).

The PDS is divided into four parts. In Part 1, the individual must indicate all the traumatic events they have experienced in their lifetime from a list of possible events and then, in Part 2, state which of the events has 'bothered [them] the most'. The original version was modified for the purpose of this study to ensure that the parent answered the questionnaire in relation to the trauma experienced by their child (see Appendix 2). This was done by omitting Part 1 and replacing it with the following instruction: *"Please answer the following questions in relation to your own feelings as a result of the traumatic event that your child experienced…"* Several additional questions were added to Part 2: time since the child's trauma; whether anyone else was physically injured or felt their life was threatened; and if the parent had felt terrified or helpless during their child's trauma.

The remainder of the questionnaire focuses on the main diagnostic criteria for PTSD and these were unaltered. Part 3 contains the 17 DSM-IV PTSD symptoms which are rated for frequency over the past month on a 4-point scale (0 = not at all / only one time to 3 = 5 or more times a week / almost always). Total scores on the measure range from 0 to 51. Three subscale scores are also generated for reexperiencing symptoms (scores range from 0-15), avoidance symptoms (scores range from 0-21), and hyperarousal symptoms (scores range 0-15). This section also includes a further two questions

inquiring about the length of time the symptoms have been present and how long after the trauma the symptoms first occurred.

Part 4 assesses areas of functional impairment arising from any PTSD symptoms. It contains 9 items and requires the individual to indicate whether or not the problems identified in Part 3 have interfered with various areas of their life.

Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith, 1983): The HADS assesses anxiety and depression in adults (see Appendix 3). It has good validity and reliability against clinical diagnosis (Zigmond & Snaith, 1983) and has been validated in adults across various settings, including normal community populations, psychiatric outpatients and primary care, to identify clinically significant anxiety and depression (e.g. Mykletun et al, 2001; Runkewitz et al, 2006). It has been shown to have a good factor structure, good subscale correlations (sharing 30% of the variance), and high internal consistency in both the anxiety and depression subscales (e.g. α = .80 and .76 respectively; Mykletun et al, 2001).

Respondents rate the frequency (0 = Not at all, 3 = Most of the time) over the past week of 14 symptoms of depression and anxiety. The questionnaire generates scores for two subscales: anxiety and depression (ranging from 0 to 21 for each subscale). A score of 8–10 on either subscale implies borderline caseness, and scores of 11+ on either subscale suggests the presence of an anxiety or depressive disorder .

Screen for Child Anxiety Related Disorders – Parent Version (SCARED-P; Birmaher et al, 1997; 1999). This questionnaire is used in clinical settings to screen for childhood anxiety disorders. The original version of the SCARED consisted of 38 items and 5 factors that parallel the DSM-IV classification of anxiety disorders: panic/somatic, generalised anxiety, separation anxiety, social phobia, and a pertinent simple phobia, school phobia. It has been found to have moderate parent-child agreement (intraclass correlation coefficients = 0.37-0.62) and good internal consistency (α = 0.7-0.9), test-retest reliability (p = 0.6-0.9), and discriminant validity both between anxiety and depressive and disruptive disorders and within anxiety disorders (Birmaher et al, 1997).

It contains 41-items asking the parent about the severity of their child's anxiety symptoms for the past 3 months using a 3-point scale ranging, with 0 meaning 'not true

or hardly ever true', 1 meaning 'sometimes true', and 2 meaning 'true or often true' (see Appendix 4). A total score of ≥ 25 may indicate the presence of an anxiety disorder. Scores higher that 30 are more specific. Because the social factor did not discriminate well between social phobia and other anxiety disorders, 3 items were added to the original 38-item version. These items were as follows: 'My child feels nervous when he/she is with other children or adults and he/she has to do something while they watch him/her', 'My child feels nervous when he/she is going to parties, dances, or any place where there will be people that he/she doesn't know well', and 'My child is shy'.

Short Moods and Feelings Questionnaire – Parent Version (SMFQ-P; Angold et al, 1995) is a brief, easy-to-administer, meausure of childhood and adolescent depression, designed for the rapid evaluation of core depressive symptomatology or for use in epidemiological studies. The SMFQ was developed as a short form alternative to the *Mood and Feeling Questionnaire – Parent Version* (MFQ-P; Angold & Costello, 1987), a 32-item questionnaire based on DSM-III-R criteria for depression, with high internal reliability (Cronback's $\alpha = 0.90$). A subgroup of items most closely linked to the depression variable measured by the MFQ was selected to reduce redundancy and increase the criterion-related performance of the final SMFQ. The items selected were the 13 items (see Appendix 5) which had performed well in a variety of analyses. The SMFQ was found to have a high internal consistency ($\alpha = 0.87$ for the parent), high discriminant validity, and substantial correlations with the Children's Depression Inventory ($r = .67$) (CDI; Kovacs, 1983) and the Diagnostic Interview Schedule for Children ($r = .65$) (DISC; Costello et al, 1982) depression scale. Correlations between parent and child were at the expected level of around 0.2-0.4.

The SMFQ consists of a series of 13 descriptive phrases regarding how the parent thinks the child has been feeling or acting recently, using a 3-point scale which reflects whether the phrase was descriptive of the subject most of the time (2), sometimes (1), or not at all (0) in the past two weeks.

Family Environment Scale (FES; Moos & Moos, 1994): The FES measures actual, preferred and expected familial atmosphere via 90 items (10 subscales) assessing three sets of dimensions: interpersonal relationship; personal growth (or goal orientation); and system maintenance (see Table 2). The relationship and system maintenance dimensions primarily reflect internal family functioning, whereas the personal growth dimensions

primarily reflect the linkages between the family and the larger social context. Ten scores derived from the subscales create an overall profile of the family environment. In addition, three separate forms of the FES are used to measure perception of the family. The Real Form (Form R) measures people's attitude about their family current environment, the Ideal Form (Form I) measures person's ideal family perception, and the Expectations Form (Form E) assesses the family ability to withstand change. Only Form R was utilised in the present study (see Appendix 6).

The FES has been used clinically to (i) understand individuals' perceptions of their nuclear families, for example, as part of family counseling or education programs, (ii) formulate clinical case descriptions and understand the impact of the family on adaptation (iii) monitor change and promote improvement in families, (iv) describe and compare family climates and contrast partners' perceptions or parents' and children's perceptions, (v) predict and measure the outcome of treatment, (vi) focus on how families adapt to life transitions and crises, and (vii) understand the impact of the family on children and adolescents (Moos, 1974, 1994, 2002, 2009).

The FES has been translated and adapted for use in a number of European, Asian, and African countries. The internal consistencies (Cronbach's alpha) for each of the 10 FES subscales have all been found to be in an acceptable range and vary from moderate to substantial (Moos, 1994). The test-retest reliabilities on the 10 subscales for individuals who took Form R twice with a 2-month interval were all in an acceptable range, varying from a low of .68 to a high of .86. Test-retest reliabilities were also relatively high for a 4-month interval (Moos, 1994).

Table 2: FES subscales and descriptions

Relationship Dimensions	
1. Cohesion	the degree of commitment, help and support family members provide for one another
2. Expressiveness	the extent to which family members are encouraged to express their feelings directly
3. Conflict	the amount of openly expressed anger and conflict among family members
Personal Growth Dimensions	
4. Independence	the extent to which family members are assertive, are self-sufficient and make their own decisions

5. Achievement / orientation	how much activities (such as school and work) are cast into an achievement-oriented or competitive framework
6. Intellectual-cultural orientation	the interest in political, intellectual, and cultural activities
7. Active-recreational orientation	the amount of participation in social and recreational activities
8. Moral-religious emphasis	the emphasis on ethical and religious issues and values
System Maintenance Dimensions	
9. Organisation	the degree of importance of clear organisation and structure in planning family activities and responsibilities
10. Control	how much set rules and procedures are used to run family life

2.3.2 CHILD COMPLETED MEASURES

Child PTSD Symptom Scale **(**CPSS; Foa et al, 2001): The CPSS is a child version of the PDS (Foa, 1995). It contains 23 items and has a very similar format to the adult version but uses developmentally appropriate language and areas of possible impairment. The CPSS is shown to have high internal consistency (r = .89) and test-retest reliability (r = .84), and shows good agreement with other validated measures of child PTSD (Foa et al, 2001).

The first 17 items assess the occurence / severity of the 17 DSM-IV symptoms of PTSD over the last month on a 4-point scale (0 = not at all / only one time to 3 = 5 or more times a week / almost always). A total severity score is calculated for the 17 items (range 0-51) as well as severity scores for each of the three subscales: reexperiencing (range 0-15), avoidance (range 0-21), and hyperarousal (range 0-15). Items 18 to 23 assess functional impairment (0 = No; 1 = Yes) from the PTSD symptoms generating an overall functional impairment score (range 0-6) (see Appendix 7).

Child Post-Traumatic Cognitions Inventory (cPTCI; Meiser-Stedman, 2003): This 25-item questionnaire measures the frequency of negative appraisals since the traumatic incident (see Appendix 8). The items are derived from the adult PTCI (Foa et al, 1999) but have been amended for use with children and adolescents. The child rates how much they agree or disagree with 25 beliefs statements on a 4-point scale (1 = Don't agree at all, 4 = Agree a lot). The questionnaire generates 2 subscale scores: 'Permanent

Change' (13 items, range = 13-52) and 'Vulnerable Person in a Scary World' (12 items, range = 12-48).

The cPTCI has been standardised for use in children and adolescents who have been exposed to traumatic events (Meiser-Stedman, 2003). It has been found to have high internal consistency (α = .88 for both subscales). It also shows good agreement with other validated measures of child PTSD symptoms, for example, significant correlations were found between the Revised Impact of Events Scale for Children (RIES-C; Smith et al, 2003) and each subscale of the cPTCI ('permanent change' subscale: r = .68; 'vulnerable' subscale: r = .67). In addition, children's endorsement of negative appraisals on the cPTCI after experiencing trauma has been found to significantly predict PTSD severity (Bryant et al, 2007).

Screen for Child Anxiety Related Disorders – Child Version (SCARED-C; Birmaher et al, 1997; 1999). This questionnaire is used in clinical settings to screen for childhood anxiety disorders (see Appendix 9). The original version of the SCARED consisted of 38 items and 5 factors that parallel the DSM-IV classification of anxiety disorders: panic/somatic, generalised anxiety, separation anxiety, social phobia, and a pertinent simple phobia, school phobia. It has been found to have moderate parent-child agreement (intraclass correlation coefficients = 0.37-0.62) and good internal consistency (α = 0.7-0.9), test-retest reliability (p = 0.6-0.9), and discriminant validity both between anxiety and depressive and disruptive disorders and within anxiety disorders (Birmaher et al, 1997). In addition, the SCARED showed good convergent and divergent validity when compared with the Child Behaviour Checklist (Achenbach & Edelbrock, 1983) and the State-Trait Anxiety Inventory for Children (Spielberger, 1973), and was found to have the same 5 factors described above and good psychometric properties in a large community sample of Dutch school-age children and adolescents (Murius & Merckelbach, 1998).

It contains 41-items asking about the severity of anxiety symptoms for the past 3 months using a 3-point scale ranging, with 0 meaning 'not true or hardly ever true', 1 meaning 'sometimes true', and 2 meaning 'true or often true'. A total score of ≥ 25 may indicate the presence of an anxiety disorder. Scores higher that 30 are more specific. Because the social factor did not discriminate well between social phobia and other anxiety disorders, 3 items were added to the original 38-item version. These items were

as follows: ‘I feel nervous when I am with other children or adults and I have to do something while they watch me’, ‘I feel nervous when I am going to parties, dances, or any place where there will be people that I don’t know well’, and ‘I am shy’.

Short Mood and Feelings Questionnaire – Child Version (SMFQ-C; Angold et al, 1995) is a brief, easy-to-administer, self-report meausure of childhood and adolescent depression, designed for the rapid evaluation of core depressive symptomatology or for use in epidemiological studies. The SMFQ was developed as a short form alternative to the *Mood and Feelings Questionnaire – Child Version* (MFQ-C; Angold & Costello, 1987), a 32-item questionnaire based on DSM-III-R criteria for depression, with high internal reliability (Cronback’s $\alpha = 0.90$). A subgroup of items most closely linked to the depression variable measured by the MFQ was selected to reduce redundancy and increase the criterion-related performance of the final SMFQ. The items selected were the 13 items (see Appendix 10) which had performed well in a variety of analyses. The 13 items of the SMFQ-C alone achieved 60% sensitivity and 85% specificity at a cut-off score of 8 or more. The SMFQ was found to have a high internal consistency ($\alpha = 0.85$ for the child), high discriminant validity, and substantial correlations with the Children’s Depression Inventory ($r = .67$) (CDI; Kovacs, 1983) and the Diagnostic Interview Schedule for Children ($r = .65$) (DISC; Costello et al, 1982) depression scale. Correlations between parent and child were at the expected level of around 0.2-0.4.

The SMFQ consists of a series of 13 descriptive phrases regarding how the child has been feeling or acting recently, using a 3-point scale which reflects whether the phrase was descriptive of the subject most of the time (2), sometimes (1), or not at all (0) in the past two weeks.

Talking About Trauma Questionnaire (TATQ): this was an additional (new) questionnaire developed with parallel items for the parent (TATQ-P) and child (TATQ-C) (see Appendix 11), assessing the parent and child's willingness to talk to each other about the trauma and their feelings. This measure is more specific to the trauma aftermath and atmosphere within the family, and assesses: (i) parent’s and child’s trauma-related beliefs and coping strategies and whether the effects of the traumatic event on the interaction between them is bidirectional, for example by children and parents negatively reinforcing each other for both avoiding talking about the traumatic event for fear of upsetting each other, and (ii) whether the child and parent would like to talk about the event and what they think their loved ones’ reaction would be (e.g.

become upset, angry, anxious etc). Examples of items are the following: (1) 'I prefer not to talk to mum/child about what happened'; (2) 'Talking to mum/child makes me upset'; (3) 'Talking to mum/child makes child/mum upset'; (4) 'I don't want mum/child to be reminded of what happened'; (5) 'I keep my feelings to myself'; and other items (with reversed rating scores) like (6) 'Talking to my mum / my child makes me feel better' and (7) 'Talking to my mum / my child makes my mum / my child feel better'. In total, the questionnaire contained 16 items and the child and parent were asked to rate how much they would agree with each statement, using a 3-point scale (0-2). The psychometric properties of the new measure are described in the Results section in the Preliminary Analysis.

2.4 DEMOGRAPHIC AND BACKGROUND INFORMATION

Basic demographic information about each family was collected, including the gender and age of the child and the gender of the parent. Background information about the traumatic event was also recorded, including the date of the event (in order to record the duration of time since the trauma had occurred), and whether or not the parent was directly involved in the traumatic event. For the children who were seen further on in treatment, further information collected included the duration of time since the baseline initial assessment (in months) and the total number of therapy sessions received.

2.5 INTERVIEW MEASURE OF EXPRESSED EMOTION (EE)

The *Five Minutes Speech Sample* (FMSS; Magana et al, 1987) has already been described in Part C of the Introduction. Briefly, the FMSS is a measure of EE that is used as a less time consuming alternative to the Camberwell Family Interview (CFI; Leff & Vaughn, 1985) previous in research with carers of people with psychosis (Bachmann et al, 2002; Barrowclough et al, 2001; Heikkila et al, 2007; Lobban et al, 2006; Tompson et al, 1995). The FMSS demonstrates a high level of agreement with the CFI, the standard for measuring EE (Magana et al, 1987). Research illustrates that results on the FMSS correlate highly with the Camberwell Family Interview in terms of classification of families as high or low EE, but tend to under-rate the occurrence of high EE (Wearden et al, 2000). Studies also illustrate strong validity ($r = 0.44$) for the criticism dimension of the FMSS but note weaker validity ($r = 0.38$) for the EOI dimension (Magana et al, 1986; Malla et al, 1991; Leeb et al, 1991; van Furth et al, 1993; Wamboldt et al, 2000; Kaugars et al, 2007). With regard to reliability, Leeb et al (1991) reported good inter-rater reliability (Kappa = 0.70 - 0.80) and good test-retest

stability over four to five weeks. In addition, McGuire and Earls (1994) reported significant test-retest stability over an average of 22 days when borderline EE scores were included.

The parent (the main caregiver) was asked to talk about their child and their relationship over a five minute period without the child being present (see Appendix 12 for full instructions). The researcher would sit in the room with the parent and would prompt the description, only if required. The speech sample was audio-taped, and then transcribed and scored using the coding system described by Magana et al (1987) (see Appendix 13 for scoring sheet). Both the tone and content of the brief speech sample were analysed. The coding system is composed of four categories: (a) initial statement, b) relationship, c) criticism, and d) emotional over-involvement. From the audio-tape of the interview it is possible to rate the overall level of EE, Criticism (CRIT) and Emotional Over-involvement (EOI). One or more critical comments, negative comments about the relationship, or a critical statement at the start of the interview are all indicative of high Criticism (Dissatisfaction) on FMSS, whereas the EOI dimension is characterised by extreme praising or loving comments about the child (FMSS Statement of Attitude), excessive emotional display, self-sacrificing or over-protective behaviours, and excessive details about the past of the child. Respondents are classified as high EE if they are high CRIT and/or high EOI. There is no hostility rating on the FMSS. Warmth is not assessed either, although the FMSS does provide a frequency count of the number of positive comments relatives make about the child.

2.6 GENERAL PROCEDURE

Potential participants were identified following their first clinical assessment, or via discussion with their treating clinicians, during team meetings where the participants were discussed and the researcher was present. Families who met criteria for entry to the study were provided an information sheet about the study by the clinician responsible for their care (see Appendix 14). Once the parent and child had read the information sheet, they were asked by the clinician if they could be contacted by the researcher about participation so that the researcher could answer any questions they might have. It was made clear to the parent and child at that time that participation in no way would affect their treatment care plan or the speed at which they would receive treatment. They were also told that they could withdraw from the study without any impact on the clinical service they were receiving.

Families that agreed to participate were seen at their next scheduled clinical session. Both parent and child completed the consent forms (see Appendix 14). For children below the age of 16, the parent was asked to give informed consent to participate for both. However we also included an 'assent' form for under 16's to complete. Any child, regardless of age who did not give either assent or consent was not included in the study. The consent and assent forms used age-appropriate language (one version for children and one for adolescents). They were again told that they could withdraw from the study without any impact on the clinical service they would receive.

The parent-child dyads that consented to participate were seen by the researcher at the clinic at which they were receiving treatment or at their home, whichever was more convenient. In order to reduce the burden on the family, participants completed the research assessment prior to their next clinical appointment or sooner if they were being wait-listed. If both parents accompanied their child to the clinic, the child's primary caregiver was asked to participate.

The primary caregiver was seen alone and asked about their child and their relationship since the trauma. Questioning followed a standard procedure for sampling expressed emotion from a 5-minute speech sample. The parent was not asked to discuss the trauma or any symptoms in detail. This procedure minimised the likelihood of the parent becoming upset by the 5-minute speech sample. If the 5-minute speech sample brought up any concerns or distress, the parent had the opportunity to discuss them with the researcher, who is a clinical psychologist in training under the supervision of qualified clinical psychologists specialised in trauma. They were also able to talk to the clinical psychologist who was seeing the family immediately after the research assessment. The five-minute speech sample was audiotaped.

After completing the audio-taped session, both parent and child completed the questionnaire measures about PTSD, trauma-related beliefs, anxiety and depression. These measures are in routine clinical use in SLAM CAMHS and are compliant with NICE recommendations for assessment of childhood PTSD. They were not expected to cause the child or parent any distress. The researcher remained in the room with the family to provide help with reading the questionnaires if either the parent or the child needed it, and ready to answer any questions they might have. Questionnaire completion took approximately thirty minutes. For participants seen in the clinic, the

FMSS and questionnaire completion were immediately followed by their regular clinical appointment.

At the time of data collection, all materials (audiotapes and questionnaires) had a research participant number and no other identifying information. A separate spreadsheet with the participant number and parent-child dyad name was kept in an encrypted Excel file. The audiotapes did not have more than a participant number on them and were kept securely locked. A separate encrypted SPSS data file was kept where the ratings of the audiotapes and the items and total scores from the questionnaires were entered.

3. RESULTS

3.1 SUMMARY OF STATISTICAL ANALYSES

Statistical advice was sought at the design stage and before any analyses were performed. Data were visually inspected for normality using histograms and quantile-quantile (Q-Q) plots for each variable. Q-Q plots showed values in the range -2 to +2 indicating normally distributed data. The asbences of skewness (whether or not the data is skewed in a positive or negative direction) and kurtosis (whether a distribution is pointy or flat) were taken as further evidence of the data being normally distributed. Descriptive statistics were examined for all data collected, in the form of means (M), standard deviations (SD), percentages, frequencies and ranges.

Pearson's correlation coefficients (r) were obtained to investigate relationships between continuous variables with normal distributions. To capture the relationships between continuous variables and dichotomous variables (e.g. High and Low EE) point-biserial correlations were used. For the purposes of interpreting the strength of the correlation, Cohen (1988) recommends that, in behavioural sciences research, correlation coefficients of .10 to .29 should be considered weak, .30 to .49 considered moderate, and .50 to 1.00 considered strong. Whilst the correlation coefficient is an effect size in its own right (with correlations >.3 considered reasonable), significance values (p) of all correlations are also presented.

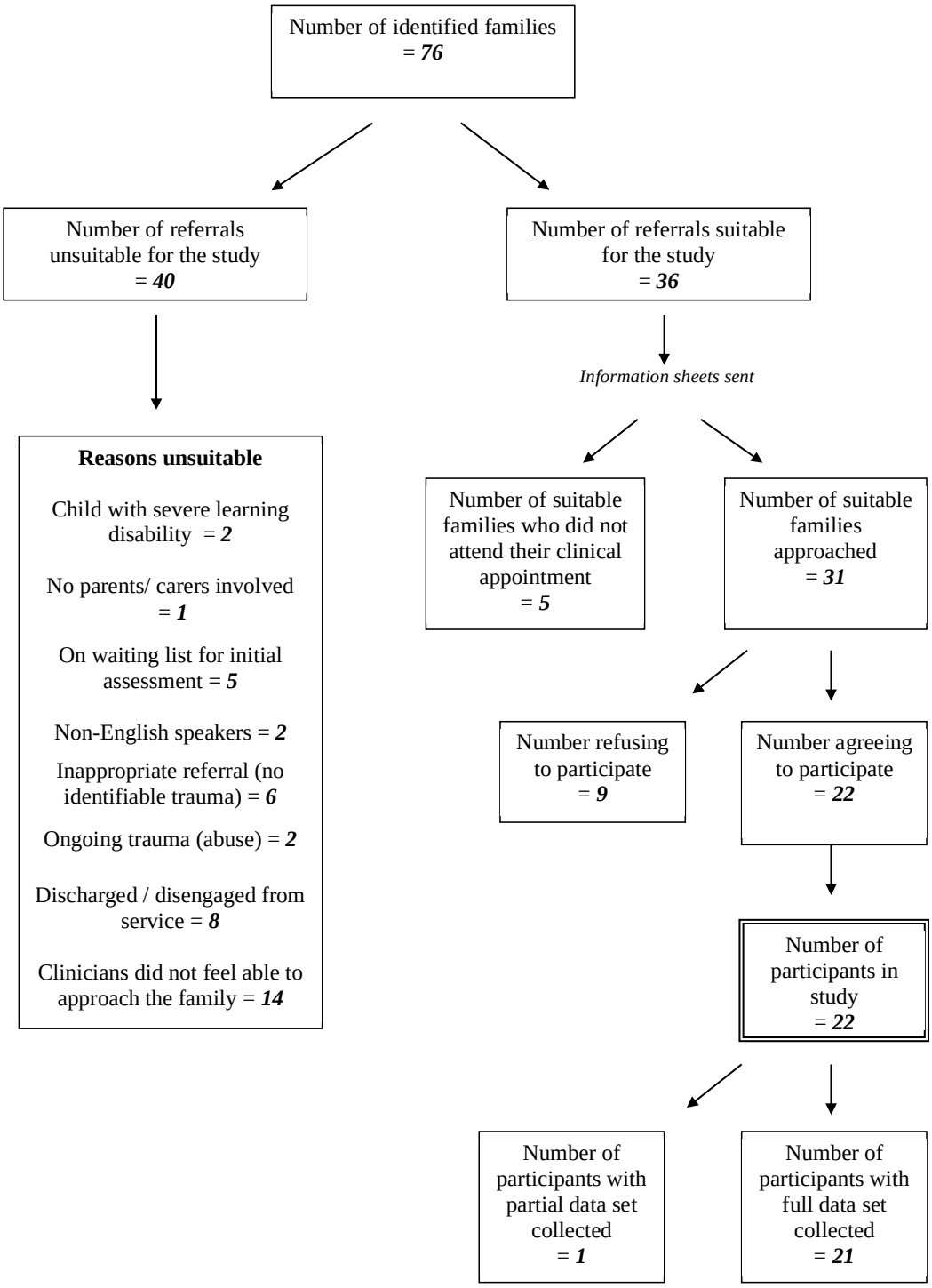
3.2 PRELIMINARY ANALYSES

3.2.1 PARTICIPANTS

Twenty-two parent-child dyads (61.1% of the total number of suitable referrals) participated in the study. As one of the parents did not complete the questionnaires some analyses were based on N = 21. Participants were 11 males (50%) and 11 females (50%) with a mean age of 12.05 years (SD = 3.19; range = 7-17 years). Eighteen took part in the study with their mothers (81.8%), followed by two with their fathers (one biological and one adoptive), one with their foster carer (woman) and one with their maternal aunt. All the participating adults were the primary caregivers for their child.

It was not possible to recruit the number of participants suggested by the a priori power analyses (i.e. N = 47), largely owing to changes in overall staffing and referral pathways across CAMHS that arose from Trust-wide financial pressures. Within the 9-month recruitment time frame (September 2011 to May 2012), 76 cases were identified from the Child Traumatic Stress Clinic and community CAMHS teams, although due to the various exclusion criteria (e.g. the parents being non-English speakers, the child presenting with a severe learning disability, the trauma being ongoing, etc), only 36 (47.4%) of these families were suitable to approach for this study.

Figure 2. Flow-diagram to show the recruitment process at the Child Traumatic Stress Clinic and Community CAMHS.



3.2.2 CLINICAL CHARACTERISTICS OF THE SAMPLE

3.2.2.1 TRAUMA EXPOSURE

All the participants underwent a thorough background and diagnostic assessment carried out by a clinical psychologist. These assessments revealed exposure to a variety of traumatic events: RTAs, muggings, fires, rapes, and domestic violence. Fourteen of the parents were present during their child's trauma (66.7%); seven were not present during their child's trauma (33.3%), one parent did not answer this question. The children were assessed at the clinics at a mean duration of 10.15 months (SD = 10.10, range = 1-33 months) after the trauma occurred, offered a mean number of 6 treatment sessions (SD = 5.49, range 0-16), and seen for the current study at a mean duration of 6 months to 3 years (range = 3 months-more than 5 years) since the event occurred.

3.2.2.2 CHILD SYMPTOMATOLOGY

Table 3 presents means and standard deviations for the child-report measures of the child's PTSD, trauma-related beliefs (cPTCI), and anxiety (SCARED-C), as well as the parent-reported measures of child anxiety (SCARED-P) and depression (SMFQ-P), alongside descriptive data for the same questionnaires completed by other clinical samples of children. Based on total scores on the children's CPSS, 21 of the 22 (95.45%) fell above the clinical cut-off (11) suggestive of a current DSM-IV diagnosis of PTSD. The descriptive data found in the present sample demonstrated a high level of symptomatology.

Table 3. Means and SDs of child self-reported symptom and parent report of child symptom scores.

Measure	Mean (SD)	Other clinical samples
CPSS	28.97 (12.02)	19.1 (SD 7.1) [a]
cPTCI	40.86 (20.00)	40.35 (14.46) [b]
SCARED-Child	40.23 (23.17)	21.5 (12.4) [c]
SMFQ-Child	13.61 (7.93)	7.14 (5.19) [d]
SCARED-Parent	38.32 (16.99)	16.2 (11.3) [c]
SMFQ-Parent	11.55 (6.21)	5.79 (4.80) [d]

[a] = Children with PTSD; Foa et al (2001)
[b] = Children with PTSD; Meiser-Stedman et al (2003)
[c] = Children with anxiety disorders in primary care; Birmaher et al (1999)
[d] = Children with psychiatric disorders; Angold et al (1995)

3.2.2.3 PARENT SYMPTOMATOLOGY

Descriptive statistics for parent self-reported questionnaire measures of post-traumatic stress (PDS), anxiety (HADS Anxiety) and depression (HADS Depresion) are displayed in Table 4, alongside descriptive data for the same questionnaires completed by other clinical samples of parents. Parents demonstrated a significant level of post-traumatic stress symptomatology (scores between 21 and 35 indicating moderate to severe distress). No significant difference was found between PDS scores in the 14 parents who were directly exposed to the traumatic event (Mean = 31.21, SD = 14.78) and the 7 who were not (Mean = 23.43, SD = 10.71) [$F(1,19) = 1.965$; $p = .177$)]. Parents' mean scores on both subscales of the HADS were below the clinical cut-off point (11) for anxiety and depression.

Table 4. Means and SDs of parent self-reported symptom scores.

Measure	Mean (SD)	Other clinical samples
PDS	29.05 (13.62)	33.59 (9.96) [a]
HADS anxiety	9.48 (4.99)	10.50 (3.80) [b]
HADS depression	7.16 (4.92)	8.10 (3.40) [b]

[a] = Adults with PTSD; Foa et al (1997)

[b] = Adults with psychiatric disorder in Primary Care; Runkewitz et al (2006)

3.2.2.4 TALKING ABOUT TRAUMA QUESTIONNAIRE (TATQ)

Descriptive statistics for the TATQ-C and TATQ-P, the measure of family post-trauma communication, are displayed in Table 5. The questionnaire contained 16 items and the child and parent were asked to rate how much they would agree with each statement, using a 3-point scale (0-2), for a maximum score of 32, with lower scores indicating a higher willingness to talk to each other about the trauma and their feelings, and vice versa. Therefore, as shown in Table 5, both the children and parents scored in the average range.

Table 5: Means and SDs of the TATQ-C and TATQ-P

Measure	Mean (SD)
TATQ-CHILD	16.14 (7.77)
TATQ-PARENT	14.63 (5.29)

3.2.2.5 FAMILY ENVIRONMENT SCALE (FES)

Descriptive statistics for the subscale dimensions of the FES, the measure of family environment completed by the participating parent (only), are displayed in Table 6. Children did not complete the FES. The measures reported below are T scores with a mean of 50 and a standard deviation of 10. Therefore the dimensions of family environment were all in the average range.

Table 6: Means and SDs for the Parent-Completed FES subscale.

FES Dimensions	Scaled Scores Mean (SD)
Cohesion	50.62 (11.17)
Expressiveness	50.10 (10.99)
Conflict	51.48 (11.69)
Independence	43.86 (13.21)
Achievement / orientation	45.57 (9.08)
Intellectual-cultural orientation	48.62 (11.92)
Active-recreational orientation	47.29 (10.61)
Moral-religious emphasis	47.67 (10.52)
Organisation	48.43 (9.25)
Control	52.67 (7.97)

3.2.2.6 PARENTAL EXPRESSED EMOTION (FIVE-MINUTE SPEECH SAMPLE – FMSS)

The frequency of parents who scored High, Borderline and Low EE on the FMSS is displayed in Table 7. High EE is assigned when one of the following is present: Criticism (CRIT), Emotional Overinvolvement (EOI), or both Criticism and Emotional Overinvolvement (CRIT + EOI). A Borderline EE rating is given to speech samples which contain evidence for, but do not qualify as High EE.

Table 8 illustrates the frequency of parents in the High EE group on the FMSS task who fell into the CRIT, EOI, and CRIT + EOI subgroups. Scores on the subscale of the CRIT and EOI dimensions for all 22 parents can be seen in Tables 9 and 10, respectively.

Table 7: Frequencies of High / Borderline / Low EE parents as measured by the FMSS.

	N = 22
High EE	6 (27.3%)
Borderline EE	3 (13.6%)
Low EE	13 (59.1%)

Table 8: Frequencies of Criticism (CRIT) and Emotional Over-involvement (EOI) in parents rated as High EE on the FMSS.

	N = 6
CRIT dimension	2 (9.2%)
EOI dimension	1 (4.5%)
CRIT + EOI dimensions	3 (13.6%)

Table 9: Scores on criticism (CRIT) subscales from the FMSS

	N = 22
Initial statement	
Positive + Neutral	8 + 12
Negative	2
Quality of relationship	
Positive + Neutral	5 + 14
Negative	3
Criticism	
Absent	16
Present (one or more)	6
Dissatisfaction	
Absent	13
Present (one or more)	9

Table 10: Scores on emotional over-involvement (EOI) subscales from the FMSS

	N = 22
Self-sacrificing / over-protective behavior / lack of objectivity	
Present	5
Absent	17
Emotional display	
Present	3
Absent	19
Excessive detail about the past	
Present	5
Absent	17
Excessive praise (5 o more positive remarks)	
Present	3
Absent	19
Statements of attitude	
Present	1
Absent	21

3.2.3. ANALYSIS OF THE VALIDITY AND RELIABILITY OF THE TALKING ABOUT TRAUMA QUESTIONNAIRE (TATQ)

3.2.3.1. VALIDITY

Face Validity: This is the most basic and fundamental form of validity and it refers to whether, on the face of it, the instrument looks like it is measuring what it intends to. In line with good practice guidance on service user involvement in delivery of clinical services, children and parents were verbally asked to provide feedback about the new questionnaire. Participants were explicitly involved during the development of the study questionnaire which made the questionnaire more ecologically valid and meaningful to their needs.

Content Validity: This refers to the extent to which the content of a measure covers all aspects of the domain that has been specified in the operational definition. The TATQ was developed to capture the nature of the child's and parent's beliefs about talking

about the traumatic event with each other and the effects of doing so. Items for the questionnaire were generated by the researcher alongside Drs Sean Perrin and Patrick Smith, both experts in childhood trauma, with long experience of working with traumatised families and conducting research on the same. The final items used were chosen to reflect the most commonly reported beliefs of children and parents seen in a specialist trauma clinic about the consequences of talking about the traumatic event with each other. Thus, the measure would appear to have good content and face validity.

Criterion Validity: This examines whether the new measure correlates with measures of related constructs (construct or convergent validity), however no validated measures exist that explore similar content to the TATQ. Criterion validity is also examined via its correlation with similar instruments that are already known to be valid and administered simultaneously (concurrent validity). Therefore, we were able to look at the relationship between the TATQ (child and parent versions) and other child and parent self-reported measures.

Table 11 displays the correlations between the TATQ-C and the child-completed measures. Moderate to strong, positive correlations (all significant) were observed between the child new measure of the post-trauma family communication (TATQ-C) and the child self-reported dysfunctional trauma-related beliefs (cPTCI), anxiety (SCARED-C) and depression (SMFQ-C).

Table 11: Pearson correlations between the child measure of post-trauma family communication (TATQ-C) and child self-reported measures.

Child-reported symptoms	TATQ-Child
cPTCI	**r = .684** (p = .000) **
SCARED-Child	**r = .721** (p = .000) **
SMFQ-Child	**r = .592** (p = .0084) **

** = p≤ .01

Table 12 displays the correlations between the TATQ-P and the parent-completed measures. Moderate to strong, positive correlations (all significant) were observed

between the parent measure of post-trauma family communication (TATQ-P) and the parent self-reported measures of PTSD (PDS), anxiety (HADS Anxiety), and depression (HADS Depression).

Table 12: Pearson correlations between the parent measure of post-trauma family communication (TATQ-P) and parent self-reported measures.

Parent-reported symptoms	TATQ-P
PDS	**r = .575** (p = .005) **
HADS anxiety	**r = .522** (p = .015) *
HADS depression	**r = .693** (p = .000) **

* = p≤.05 ** = p≤ .01

3.2.3.2 RELIABILITY

A reliable measure is one that yields similar results when repeated on two or more occasions within a brief time span. There are various forms of reliability, some or all of which may be appropriate to investigate depending on the goal of the instrument. Regardless of the method, correlations of 0.7 or above are considered to reflect an acceptable level of reliability between two administrations of the same measure to the same person/group (Nunnally & Bernstein, 1994).

Internal consistency: This is the standard method of assessing whether the items within a measure are all tapping the same underlying construct (high consistency) or different constructs (low consistency). This is typically investigated by calculating inter-item correlations, and by covarying all the items with each other using an index known as 'Cronbach's alpha'. Inter-item correlations were calculated: the TATQ-C had good internal consistency, with a Cronbach alpha coeficient of .870, and the TATQ-P had acceptable internal consistency, with a Cronbach alpha coeficient of .699.

With a larger sample size, it would have been interesting to conduct a factor structure analysis. This principal components analysis might have suggested a component structure, and it would have been interesting to assess the internal consistency, test-retest reliability, convergent validity, and discriminative validity of each component.

In addition, by using the TATQ in a longitudinal design, it would have been possible to measure the test-retest reliability.

The TATQ is a reliable and valid measure that is not specific to the type of trauma exposure, and shows considerable promise as a research and clinical tool. The structure of this measure suggests that post-trauma communication is a pertinent factor in trauma-exposed children and adolescents.

3.2.4 ANALYSIS OF THE INTER-RATER RELIABILITY OF THE FMSS

Establishing good inter-rater reliability of the FMSS was fundamental to ensure that this measure was useful. The primary coder (FC) met with two other raters on four occasions to discuss ratings and to ensure that the coding system was consistently applied. The two other raters were Trainee Clinical Psychologists, both of whom had been trained by their supervisors to use the CFI. Templates of speech samples were blindly rated prior to coding. All of the FMSSs were also coded by the primary coder (FC) and 45% of these speech samples were double-coded by one of the two other raters to test inter-rater reliability. A Kappa of 0.783 was achieved between the primary rater (FC) and the other raters. Kappas in excess 0.7 indicate a high level of agreement between raters (Landis & Koch, 1977).

3.3 MAIN FINDINGS

3.3.1 HYPOTHESIS ONE: PARENTAL EE, AS MEASURED BY THE FIVE MINUTES SPEECH SAMPLE (FMSS), WILL CORRELATE MODERATELY AND SIGNIFICANTLY WITH THE CHILD'S SELF-REPORTED PTSD AS MEASURED BY THE CHILD PTSD SYMPTOM SCALE (CPSS).

For the present analyses, the speech samples rated as Borderline EE were considered High EE as suggested in the FMSS Manual (Magana, 1993), which states that for some populations (e.g. groups that are reluctant to express strong attitudes about their relatives, for example parents of young children, as in the current study) a lower threshold for high EE might be appropriate.

Contrary to expectations, high levels of parental expressed emotion as measured by the FMSS were very weakly correlated with the child's self-reported symptoms of PTSD (CPSS), as shown in Table 13.

Table 13: Point-biserial correlations between parental EE and child-reported PTSD.

Five Minute Speech Sample	CPSS
High Low EE	r = .009 (p = .967)
Initial Statement	r = -.149 (p = .509)
Relationship	r = -.023 (p = .918)
Criticism	r = -.140 (p = .534)
Dissatisfaction	r = .037 (p = .870)
Emotional Display	r = .057 (p = .800)
Statements of Attitude	r = .186 (p = .406)
Self-sacrificing/lack of objectivity/over-protective behaviour	r = .167 (p = .457)
Excessive detail about the past	r = .066 (p = .771)
Positive remarks	r = -.011 (p = .963)

3.3.2 HYPOTHESIS TWO: FAMILY ENVIRONMENT, AS MEASURED BY THE FAMILY ENVIRONMENT SCALE (FES), WILL CORRELATE MODERATELY AND SIGNIFICANTLY WITH THE CHILD'S SELF-REPORTED PTSD AS MEASURED BY THE CPSS.

Contrary to expectations, family cohesion, expressiveness, conflict, and the other family environment dimensions, as measured by the parent-completed FES, were very weakly

correlated with the child's self-reported symptoms of PTSD (CPSS), as shown in Table 14.

Table 14: Pearson correlations between dimensions of the parent-completed Family Environment Scale and child-reported PTSD.

FES dimensions	CPSS
Cohesion	r = .147 (p = .525)
Expressiveness	r = -.272 (p = .232)
Conflict	r = -.327 (p = .148)
Independence	r = . 238 (p = .298)
Achievement / orientation	r = -.087 (p = .709)
Intellectual-cultural orientation	r = .083 (p =.720)
Active-recreational orientation	r = -.237 (p = .301)
Moral-religious emphasis	r = .272 (p = .234)
Organisation	r = .067 (p = .773)
Control	r = .366 (p = .103)

3.3.3 HYPOTHESIS THREE: FAMILY POST-TRAUMA COMMUNICATION, AS MEASURED BY THE TALKING ABOUT TRAUMA QUESTIONNAIRE – CHILD AND PARENT VERSIONS (TATQ-C AND TATQ-P), WILL COLLERATE MODERATELY AND SIGNIFICANTLY WITH THE CHILD SELF-REPORTED PTSD AS MEASURED BY THE CPSS.

As shown in Table 15, a strong, positive correlation (significant) was observed between the child new measure of the post-trauma family communication (TATQ-C) and the child self-reported symptoms of PTSD (CPSS), indicating that greater post-trauma symptomatology was associated with the child having greater difficulty (and inhibition) talking about the trauma with their family. However, the correlation between the parent version of the new measure of post-trauma family communication (TATQ-P) and the child self-reported PTSD (CPSS) was weak, as shown in Table 15.

Table 15: Pearson correlations between the child measure of post-trauma family communication (TATQ-C) and child self-reported measure of PTSD.

TATQ	CPSS
TATQ-C	**r = .643** (p = .001) **
TATQ-P	r = -.138 (p = .540)

** = p≤ .01

3.3.4 HYPOTHESIS FOUR: PARENTAL SYMPTOMS OF PTSD, ANXIETY, AND DEPRESSION WILL BE MODERATELY AND SIGNIFICANTLY ASSOCIATED WITH THE CHILD SELF-REPORTED PTSD AS MEASURED BY THE CPSS.

Contrary to expectations, there were no significant correlations between parental self-reported symptoms of PTSD, depression and anxiety and child PTSD symptomatology, as shown in Table 16.

Table 16. Pearson correlations between child PTSD and parent self-reported symptoms.

Parent self-reported measures	CPSS
PDS	r = -.156 (p = .489)
HADS Depression	r = -.281 (p = .217)
HADS Anxiety	r = -.428 (p = .053)

4. DISCUSSION

4.1 OVERVIEW

This chapter aims to summarise and discuss the findings of the present study. The chapter will start by summarising the aims and methods of the study. The main results will then be summarised and discussed, considering each of the aims and predictions in turn. A general discussion of the study's findings will follow, including consideration of the limitations and other underlying issues, as well as the potential clinical and research implications. Finally, suggestions for future research will be described, followed by the final conclusions of the study.

4.2 SUMMARY OF THE AIMS AND METHODS

This study recruited a clinical sample of children, who were referred to child mental health services for symptoms of PTSD, and their parents. The study's primary aim was to explore the potential associations between parental and family functioning with child PTSD symptomatology. Given that research findings have been mixed, determining additional factors affecting children exposed to trauma was important. Therefore the present study offers a unique contribution to the research in the field of post-trauma environmental variables as risk factors for the maintenance of PTSD symptoms in children and adolescents, by focusing on parental expressed emotion, family environment, family post-trauma communication, and parent symptomatology.

In order to explore previously researched constructs, increase reliability of results and decrease bias, this study used a mixture of widely used, valid and reliable interview-based and questionnaire-based methods. In addition, in order to explore family post-trauma communication in this particular clinical population, the study aimed firstly to develop a new reliable and valid questionnaire to measure the parent and child communication with each other.

4.3 SUMMARY OF THE MAIN FINDINGS

To summarise, the main findings from the present study are as follows:

i. This is a clinical and symptomatic sample, both parents and children. Child PTSD symptoms were largely associated with comorbid psychological problems (depression and anxiety) and trauma negative appraisals.

ii. Parental criticism and emotional over-involvement were not related to the severity of the child's PTSD symptoms.

iii. Parental report on family environment was not related to the severity of the child's PTSD symptoms.

iv. Poor family post-trauma communication, as reported by the child, was associated with higher child PTSD symptomatology.

v. There was no association between child and parent PTSD symptoms.

4.4 POSSIBLE EXPLANATIONS FOR THE FINDINGS IN THE CONTEXT OF THE LITERATURE AND LIMITATIONS OF THE PRESENT INVESTIGATION

4.4.1 HYPOTHESIS ONE: PARENTAL EE, AS MEASURED BY THE FIVE MINUTES SPEECH SAMPLE (FMSS), WILL CORRELATE MODERATELY AND SIGNIFICANTLY WITH THE CHILD'S SELF-REPORTED PTSD AS MEASURED BY THE CPSS.

Contrary to the study's hypotheses, parental expressed emotion was not associated with child PTSD symptomatology. As research examining EE in relation to PTSD is still emerging, and has been conducted mainly with adult populations, it was difficult to interpret the current study's results. Based on the results of this study, it may be reasonable to assume that parental dimensions of criticism and over-involvement do not seem to be associated with parenting a child with PTSD. It may therefore be the case that PTSD could be differentiated from the other anxiety disorders in the literature where such associations appear to have been established (Stubbe et al, 1993; Hirschfield et al, 1997; Chamberless and Steketee, 1999; Gar and Hudson, 2008). This could suggest that PTSD is less amenable to parenting influences and that such factors may therefore be less influential in the development and maintenance of the disorder. Subsequently, it could be speculated that PTSD may be more related to other mechanisms.

4.4.2 HYPOTHESIS TWO: FAMILY ENVIRONMENT, AS MEASURED BY THE FAMILY ENVIRONMENT SCALE (FES), WILL CORRELATE MODERATELY

AND SIGNIFICANTLY WITH THE CHILD'S SELF-REPORTED PTSD AS MEASURED BY THE CPSS.

Contrary to the study's hypotheses, family environment was not associated with child PTSD symptomatology. Based on the results of this study, it may be reasonable to assume that family environment does not seem to be associated with parenting a child with PTSD. It may therefore be the case that PTSD could be differentiated from the other anxiety disorders in the literature where such associations appear to have been established (Halloran et al, 2002; Linning & Kearney, 2004; Overstreet & Braun, 2000; Suveg et al, 2005). This could suggest that PTSD is less amenable to family environment influences and that such factors may therefore be less influential in the development and maintenance of the disorder. Subsequently, it could be speculated that PTSD may be more related to other mechanisms.

4.4.3 HYPOTHESIS THREE: FAMILY POST-TRAUMA COMMUNICATION, AS MEASURED BY THE TALKING ABOUT TRAUMA QUESTIONNAIRE – CHILD AND PARENT VERSIONS (TATQ-C AND TATQ-P), WILL CORRELATE MODERATELY AND SIGNIFICANTLY WITH THE CHILD'S SELF-REPORTED PTSD AS MEASURED BY THE CPSS.

The child self-reported measure of PTSD was largely associated with the child version of the new measure on family post-trauma communication, indicating that poor family post-trauma communication, as reported by the child, was related to higher levels of child PTSD symptoms. The association between PTSD symptoms and poor communication about the trauma in the child indicates poor family post-trauma communication as a potential risk factor for PTSD and this factor represents an important target for future investigation. This relationship may merely reflect the overlap with the core avoidance symptoms of PTSD. Theoretically, this supports the cognitive model's assertion that avoidance is central to the symptomatology. Additionally, this suggests that family post-trauma communication may play a major role in the development of more significant and persistent PTSD symptoms. As this finding is the result of an exploratory study and has not been examined in previous studies it needs to be confirmed in future research. In addition, these results must be interpreted with caution due to the relatively modest sample size. However, with the behavioural and cognitive models in mind, it seems logical that significant others around the traumatised child may influence their trauma-related beliefs and symptoms, by discouraging trauma discussion. One can therefore hypothesise that the parent's

trauma-related communication may have an impact on their child's beliefs / behaviours, which in turn have an impact on the child's level of PTSD. Overall, these exploratory results suggest that poor communication reported by the parent may be associated with their own PTSD symptoms, but not directly related to their child's PTSD symptomatology. The child's self-reported poor communication on the other hand may be associated with their own post-traumatic stress symptoms. However, stronger confirmation would have derived from cross-reporting (e.g. parent TATQ being associated with child symptoms).

4.4.4 HYPOTHESIS FOUR: PARENTAL SYMPTOMS OF PTSD, ANXIETY, AND DEPRESSION WILL BE MODERATELY AND SIGNIFICANTLY ASSOCIATED WITH THE CHILD'S SELF-REPORTED PTSD AS MEASURED BY THE CPSS.

The current literature suggests that parental distress has a role to play in child PTSD, and in particular that parent depression is associated with child post-traumatic stress symptomatology (e.g. Laor, 2001; Meiser-Stedman et al, 2006). The main purpose of this study was to extend this area of research to explore the role of parental EE, family environment and post-trauma communication in child PTSD. However, as the study included collecting self-report measures of both parent and child symptomatology, it was also possible to test the hypothesis that parents' self-reported distress would be associated with higher levels of child post-traumatic stress symptomatology. Interestingly, there was no association between child and parent PTSD symptoms, which is contrary to some previous findings (e.g. Smith et al, 2001), although is consistent with others (e.g. Bryant et al, 2007). Parents in the current sample demonstrated a significant level of post-traumatic stress symptomatology, and interestingly there was no difference in PTSD symptomatology regardless being exposed to the traumatic event or not, which confirms previous research findings about trauma exposure not being a main risk factor for the development and maintenance of PTSD symptoms.

4.5. FURTHER ANALYSES

As the main hypotheses were not supported, the secondary aim was to replicate previous findings regarding post-trauma individual variables (e.g. child's comorbid psychological problems and negative trauma-related appraisals) as risk factors of maintenance of PTSD symptomatology. The previous literature in this field strongly suggests that child PTSD symptomatology is associated with comorbid psychological

problems (particularly depression), and trauma-related negative appraisals. Therefore additional analyses were employed to investigate whether these results could be replicated in the present sample.

The associations found are reported in Table 17. Strong correlations (significant) were found between child reported PTSD (CPSS) and all the child self-reported measures (cPTCI, SCARED-C, SMFQ-C) indicating that higher child PTSD symptoms were associated with more negative trauma-related beliefs, higher depression and higher anxiety, as reported by the child.

Table 17. Pearson correlations between child self-reported measures

Child self-reported measures	CPSS
cPTCI	**r = .734** (p = .000) **
SMFQ-Child	**r = .815** (p = .000) **
SCARED-Child	**r = .798** (p = .000) **

** = p≤.01

These analyses suggest that the child's own trauma-related appraisals are a strong predictor of the severity of their PTSD. This would also fit with the cognitive models of PTSD and previous empirical studies which have found that trauma-related negative appraisals (cPTCI) are good predictors of child PTSD (Brewin et al, 1996; Ehlers & Clark, 2000), which highlight the fundamental importance of cognitive appraisals in the development and maintenance of PTSD, as well as with the studies demonstrating the efficacy of cognitive-behavioural interventions with children with PTSD (e.g. Cohen et al, 2004; Cohen et al, 2005; Smith et al, 2011), which are fundamentally based on these models and include treatment of the child's trauma-related appraisals (see Dalgleish et al, 2005). The literature has shown that trauma-related factors are often the most important predictors of child PTSD severity, such as level of trauma exposure (e.g. Smith et al, 2001; Bryant et al, 2007), or the child level of endorsement with negative trauma-related beliefs and thought suppression (Stallard & Smith, 2007). However, most studies show negative trauma-related beliefs and thought suppression to have a larger effect than severity of exposure (average effect size of r = .70 versus r = .29) (see

Trickey et al, 2012). It was not possible to objectively measure the severity of the trauma exposure in the present study; however the child's negative trauma-related appraisals were measured and were found to strongly correlate with the child's level of PTSD symptoms (r = .734).

In addition, in the present sample, children and adolescents demonstrated a high level of post-traumatic symptomatology in comorbidity with both anxiety and depression. This result is in line with Trickey et al (2012) meta-analysis, which demonstrated that other psychological reactions to traumatic events, such as depression or other anxiety disorders, co-occur. In the current study, strong significant correlations were found between the child self-reported measures of PTSD and depression and anxiety (r = .815 and r = .798, respectively). Once again, these findings confirm Trickey et al (2012) meta-analysis, which explored a number of features of participants' post-trauma coping and environment significant risk factors for PTSD and found that 25 studies demonstrated that comorbid psychological problems yielded large effect sizes (ranging from r = .012 to r = .069). Regardless of how comorbidity precisely relates to PTSD, its importance as a risk factor for PTSD adds weight to two points concerning the way in which clinicians consider young people's responses to trauma. Firstly, other psychological problems other than PTSD should be considered in the aftermath of trauma. Secondly, understanding how other psychological reactions (particularly depression) are elicited by trauma exposure is vital.

The cPTCI, SCARED, and SMFQ are all measures that are widely used, with good validity and reliability properties (see Methods section). The strong and significant correlations found between these questionnaires and the child reported PTSD symptomatology (CPSS) support the null findings of the current study and therefore the lack of associations between child PTSD, EE and family environment.

4.6. GENERAL DISCUSSION OF FINDINGS

Overall, the findings suggest that parental EE and family environment are not directly associated with the severity of the child's PTSD symptoms. In addition, parental PTSD symptomatology was not associated to child levels of PTSD symptoms. Factors relating to the child's post-trauma characteristics, including their negative trauma-related appraisals, depression, and anxiety, can more strongly predict their level of PTSD symptoms. However, the child's perspective on family post-trauma communication was

also largely associated with their levels of PTSD symptomatology, indicating that post-trauma environmental variables (i.e. family post-trauma communication), as reported by the child, may also play a major role in the development of more significant and persistent PTSD symptoms.

These results confirm previous studies of childhood PTSD that showed how factors relating to the trauma are consistently demonstrated to be key predictors of distress in the child. It may therefore be that trauma-related factors, such as the severity of the trauma, negative trauma-related beliefs and thought suppression, account for the largest proportion of the variance in childhood symptoms of PTSD. It was not possible to objectively measure the level of trauma exposure in the present study, as the children recruited for the study had experienced different traumatic events. However, the results did strongly suggest that trauma-related factors were most strongly associated with the child's PTSD symptoms compared to any other factors measured; specifically that the child's endorsement with negative appraisals relating to the traumatic event was found to be strongly associated with the severity of their PTSD. These results suggest that, overall, the child's negative appraisals that resulted from their traumatic experience are likely to be the most important predictor of the child's PTSD symptomatology. This would also be consistent with empirical studies with children and with the cognitive models of PTSD, which highlight the key role of trauma appraisals in the development and maintenance of PTSD (Brewin et al, 1996; Ehlers and Clark, 2000).

On the other hand, family factors have been demonstrated to be important in childhood PTSD in previous research, with particular emphasis on the influence of maternal depression and worry (e.g. Meiser-Stedman et al, 2006; Smith et al, 2001). It is likely that parents do have a 'mediating' role to play in child post-traumatic stress levels, but it is possible that the influence comes from the parents' poor communication and own PTSD symptoms, as opposed to specifically criticism and emotional over-involvement dimensions of EE, or family environment. However these variables were not directly associated to child PTSD symptoms.

4.7. ISSUES IN INTERPRETING RESULTS

The results must be considered within the context of the study's methodological limitations.

4.7.1. SMALL SAMPLE SIZE

A major limitation of the present study was the relatively small sample size, which is likely to have resulted in a lack of sufficient statistical power in testing the relationships between variables, and may account for the lack of significant correlations between some of the variables. Given the number of variables and analyses made, the larger sample size (N = 47), based on the original power calculation conducted, would have given the study more power and greater chance of finding significant effects.

It is worth emphasising, however, that this was a very difficult sample to recruit and the researcher was limited with time resources. Despite the efforts made to recruit families from the Child Traumatic Stress Clinic at the Maudsley Hospital and Community Mental Health Services, the number of families put forward for the project was not extensive. In addition, due to the study's various inclusion criteria, a number of referrals were not suitable for the study.

Additional complications included concerns from some parents regarding their child participating in the research due to their belief that the child would be upset by being reminded about the traumatic event and having to fill in questionnaires about it. Once again, these concerns and behaviours (refusal to participate) confirm the influence that significant others may have on the traumatised child and on their trauma-related beliefs and symptoms, by discouraging trauma communication.

Moreover, as reported by some of the clinicians who approached the families in the first place, some parents declined to consent after reading the current study's information sheets entitled 'Family interactions with children exposed to trauma' as they expressed concerns of being judged or blamed to be causing their child's difficulties.

4.7.2. LACK OF CONTROL GROUP

The study was also limited by the lack of a control group. It would have been beneficial to recruit a comparison group including children exposed to trauma but not presenting with symptoms of PTSD. It may be suitable to recruit this kind of control group from

emergency hospital departments, for example, as opposed to mental health services, as they will be presented with children who are involved in traumatic events (e.g. RTAs) but do not go onto develop PTSD (similar to the group recruited by Meiser-Stedman et al, 2006; Stallard et al, 2006). The inclusion of a non-clinical group of children would have made it possible to make comparisons between the groups in terms of parental and family factors. It would also have made it possible to test the discriminant validity of the new measure assessing parent-child trauma aftermath communication (the TATQ), i.e. the extent to which it can distinguish between groups of children with or without PTSD.

The present study was exploratory in nature; therefore the main aim was to simply explore parental EE and family environment in the context of children with PTSD, and the relationships between the possible variables in order to generate hypotheses about the potential role of family factors influencing the maintenance of child post-traumatic stress symptomatology, a goal which has been achieved despite the lack of a control group. It would now be appropriate to conduct a future research project using a larger sample size (thus more statistical power), including a comparison group, in order to further clarify the role of family post-trauma communication in this clinical population.

4.7.3 REPRESENTATIVENESS OF THE COHORT

In addition to the small sample size, 14 out 36 (39%) of eligible participants did not participate, and this makes it unlikely that the participants are representative of all the children referred for PTSD treatment. Therefore caution is required to generalise results.

4.7.4 DIFFERENT TIME / STAGE IN TREATMENT OF THE COHORT

It is worth acknowledging that, because of difficulties with recruitment, children who were in the middle to late stages of treatment were also included in the study. Half sample was seen pre-intervention or had just begun therapy, while the other half was seen in the middle to later stage of treatment. This could potentially explain an absence of an association between variables and confound the results as participants at later stages of treatment might score differently on measures than those about to embark, since treatment would involve talking about the trauma and reappraising cognitions etc.

4.7.5 LIMITATIONS OF THE NEW MEASURE (TATQ)

Preliminary analyses also confirmed psychometric properties of the new measure (TATQ). The absence of correlations between the new developed measure on family post-trauma communication with the two other methodologies used to measure family functioning (the FMSS used to measure EE and the FES to assess family environment) suggest that these methodologies are likely to be measuring different constructs (i.e. divergent validity).

The TATQ is an attempt to measure the beliefs held by the child and family about the potential consequences of talking about the trauma. This is very specific to (recently) traumatised families and is not an indicator of parenting and may not be an indicator of overall family functioning, at least as reported by parents on the FES. In addition, it is worth considering that the fact that there was a weak correlation between the TATQ-C and the FES may be the result of a reporting bias as there were two different informants. If the correlation between the TATQ-P and the FES is weak then that suggests that the TATQ is measuring something unrelated to what the FES measures, without undermining the TATQ psychometric properties. Also, the lack of correlation between the FMSS and the TATQ is not surprising as the first measures a general parenting construct or way of responding, and the second represents specific, situationally-bound beliefs and behaviours. They may be correlated but, again, this is not an issue of validity and reliability of the TATQ or FMSS.

4.7.6 LIMITATIONS OF THE FMSS AND FES

Both the FMSS and FES are widely used in research and demonstrated good reliability and validity, as shown by publications of their psychometric properties (described in the Methods section). However, few methodological issues need to be acknowledged as future research may benefit from considering whether alternative measures should be used and / or whether coding criteria should be modified for a child population. This may be particularly important for parental and family dimensions being assessed, as they are likely to be affected by social desirability bias, which may make it particularly difficult to obtain a valid measure.

In the FMSS parents were required to talk about their child for five minutes in the presence of a researcher. As a result, they may have been conscious that they were

under scrutiny and therefore moderated their speech rather than providing a true reflection of their attitudes regarding their child, and they may have felt that they should restrict any perceived undesirable parenting behaviours, such as being overtly critical when describing their child. The FMSS method has been widely utilised in studies using adult populations, particularly in the psychosis literature. It may be that parents have a tendency to be less critical with children, as opposed to their adult offspring whom some parents may perceive as being more responsible for their behaviours. The same social desirability bias might apply to the FES, as parents were reporting on their own family's rules and practices. For example, in the FES, parents may have selected the items that best described their perception of an ideal family, rather than their family current environment, for example under-reporting on the amount of openly expressed anger and conflict among family members, and / or over-reporting on the degree of commitment, help and support family members provide for one another. Social desirability bias may therefore limit the extent to which family environment assessed by this measure in a clinic setting can be generalised to reflect the parent and family factors which characterise every day parent-child interactions and family environment.

In addition, the criteria for scoring the FMSS has been derived from research on families of adults with psychosis and, although it has been used by a number of studies to measure EE in parents of children with a range of difficulties, no modifications have been made to the scoring or interpretation of the measure. There are important developmental considerations when applying the concept of EE, as measured by the FMSS, to research with children.

4.7.7 MULTIPLE COMPARISONS

Finally, findings must be interpreted with caution due to the multiple comparisons done, as these might have led to statistically significant results (experiment-wide risk of chance findings).

4.8. METHODOLOGICAL STRENGTHS

Notwithstanding the limitations outlined above, the current study has a number of strengths.

4.8.1 USE OF MULTIPLE METHODS

The present study aimed to increase the consistency and minimise potential bias in the

results by collecting data on family factors with complimentary methods. The current study relied on both self-report measures (parent symptomatology, family environment, and family post-trauma communication), and on an interview-based measure of EE. The interview-based measure (FMSS) has been used widely in the parenting literature (Asarnow et al, 1993; Baker et al, 2000; Gar & Hudson, 2008; Hibbs et al, 1991; Raishevich et al, 2010; Stubbe et al, 1993). By using the FMSS, it was also possible to investigate criticism and over-involvement, both of which have been shown to be key parenting variables in existing research.

4.8.2 USE OF VALID AND RELIABLE MEASURES

All the measures used demonstrated adequate reliability and validity as shown by publications of their psychometric properties (described in the Methods section).

4.9 IMPLICATIONS

The results from the present study need to be replicated in future research before any clear clinical implication can be drawn, however, one can speculate about the potential implications of these findings.

4.9.1 THEORETICAL IMPLICATIONS

The strong relationship between the child's trauma-related beliefs and PTSD symptoms has clear implications for the application of the cognitive models of PTSD in the psychological treatment of traumatised children, which includes direct work on the child's negative trauma-related appraisals. This supports the use of the trauma-focused CBT models in the treatment of children with PTSD, which are found to be effective in producing lasting symptom change (e.g. Cohen et al, 2004; Cohen et al, 2005; Smith et al, 2011).

4.9.2 CLINICAL IMPLICATIONS

This study does not support the hypotheses that family environment and parental dimensions of criticism and over-involvement may be important maintenance factors in childhood PTSD. It is therefore likely to be most beneficial to continue offering individual treatment for a child with PTSD in the first instance. Currently, Trauma-Focused Cognitive Behavioural Therapy, which focuses on an exposure component and on the treatment of the child's trauma-related appraisals, is the treatment of choice for childhood PTSD (NICE, 2005), and several studies demonstrated the effectiveness of

CBT in alleviating PTSD symptoms (Cohen et al, 2004; Cohen et al, 2005; Dalgleish et al, 2005; Smith et al, 2011).

However, there may be some benefit in addressing family post-trauma communication in treatment. The findings suggest that there may be clinical implications regarding the inclusion of direct work with parents as part of the treatment of child PTSD. Family post-trauma communication may have a role to play in the child's level of post-traumatic stress symptoms, and additional sessions with the parent to focus on encouraging trauma discussion may serve as a useful adjunct to the child's therapy. Overall, these implications highlight the importance of conducting a thorough family assessment when a child is referred to mental health services for post-traumatic stress, which should include an assessment of the parent's own PTSD symptoms and communication with their child. It may be advantageous to conduct joint therapy sessions to work on parent-child trauma communication. It may be useful to allocate time to discuss with the parents the implications of discouraging child communication about the trauma and explore with parents their beliefs about this. The parents' perceptions of their child's distress and collusion with their child's wishes for avoidance of trauma discussion may be related both to their own PTSD symptoms and related beliefs, as well as to the child's PTSD symptomatology. In addition, parents rating themselves as more likely to encourage their child to engage in trauma discussion (rather than avoid it) may be related to lower levels of impairment in the child's daily functioning. These findings have implications for the role of psychoeducation in interventions with these families. In particular, it may be important to highlight to parents their potentially therapeutic role, in terms of positively encouraging their child to engage in trauma communication, rather than avoid it.

4.9.3 IMPLICATIONS FOR FUTURE RESEARCH

Suggestions for building on and improving the design of this research have been provided throughout the discussion of the limitations and other issues affecting the interpretation of results. To summarise, it would now be appropriate to design a study with a larger clinical sample size and with the addition of a control group of children exposed to trauma but without post-traumatic stress symptoms. This would enable a comparison to be made between the children with and without PTSD in terms of family

post-trauma communication, and also establish the discriminant validity of the new developed measure.

In addition to establishing whether family post-trauma communication is related specifically to childhood PTSD, future work could also begin to examine the mechanisms that link this factor and PTSD. In order to investigate these pathways, it will be necessary for future research to employ methodologies which can provide information regarding the direction of effects, by utilising a longitudinal approach in which family post-trauma communication and child PTSD symptoms are measured over time in order to test hypotheses regarding the direction of effects. Longitudinal studies measuring family post-trauma communication before and after treatment so that changes in this factor can be linked with changes in child PTSD symptoms, by administering the TATQ before and after the child received TF-CBT and see whether there is a change in the description of family post-trauma communication, following treatment. For example, in the current study, it would have been interesting to follow up the families after the child completed therapy to explore whether, with the children's symptoms significantly improving, family post-trauma communication also altered as a result of the child's therapy. Again, this would have implications for including adjunct therapy sessions with parents in order to address issues relating to their own potentially maladaptive trauma-related beliefs and communication with their child.

Another issue that complicates the findings relates to the current absence of research in family post-trauma communication in the literature in this area and the tendency of studies to measure different family variables and constructs using varying types of methodology. As a result, it is difficult to draw conclusions with regard to the relationship between child PTSD and family post-trauma communication. It would therefore be useful to conduct further research utilising a variety of measurement techniques, such as child self-report, parent-report and observational measures which can generalise findings to day-to-day parent-child trauma communication, along with the possibility of introducing experimental tasks. In addition, researchers should carefully define the constructs being measured to ensure comparison between studies can be more easily drawn. Future research could also aim to develop additional more specific, targeted measures of family trauma communication in order to expand this field of research.

5. CONCLUSIONS

The present study findings indicate that parental expressed emotion, family environment, and parental own symptomatology may not be directly related to the child's level of PTSD symptoms. Poor family trauma-related communication, on the other hand, may have a role to play in the child's experience of post-traumatic stress, although this may be mediated by the child's negative trauma-related beliefs.

It may be the case that PTSD can be differentiated from other childhood anxiety disorders and therefore parenting behaviours of criticism and over-involvement and family environment are not associated with the development or maintenance of this disorder. This may suggest that additional factors such as family post-trauma communication, comorbid psychological problems and cognitive factors may be more influential in PTSD.

Strengths and limitations of the study have been considered and it is clear that family post-trauma communication needs further testing in this population using a larger sample in order for firm conclusions to be drawn. This is imperative in order to further inform models of anxiety development and maintenance for children with PTSD and their families. Interventions to address family post-trauma communication may be helpful in order to address possible maintenance factors in childhood PTSD and to reduce symptom severity.

The findings of the current study have some important theoretical and clinical implications. In particular, the current findings support the application of the cognitive model of PTSD and the use of the trauma-focused CBT in the psychological treatment of traumatised children. However, the findings suggest that there may be clinical implications regarding the inclusion of direct work with parents as part of the treatment of child PTSD by addressing family post-trauma communication in treatment. Family post-trauma communication may have a role to play in the child's level of post-traumatic stress symptoms, and additional sessions with the parent to focus on encouraging trauma discussion may serve as a useful adjunct to the child's therapy.

In summary, the present study offers a unique contribution to the research in the field of post-trauma environmental variables as risk factors for the maintenance of PTSD symptoms in children and adolescents, has utilised both self-report and interview-based

measures, and has been the first study to develop a measure to explore family post-trauma communication, in order to investigate the specificity of such factor in this population. Future research should attempt to examine family post-trauma communication in more detail using longitudinal, experimental and prospective research to increase our understanding of the development and maintenance of childhood PTSD.

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APPENDICES

APPENDIX 1: CONFIRMATION OF ETHICAL AND TRUST APPROVALS

FILE COPY

NRES Committee London - Camberwell St Giles
(Formerly known as The Joint South London and Maudsley and Institute of Psychiatry Research Ethics Committee)
Administrative address: Victoria House
Capital Park
Fulbourn
Cambridge
CB21 5XB

Telephone: 01223 597509
Facsimile: 01223 597645

24 June 2011

Miss Federica Corno
Trainee Clinical Psychologist
Camden & Islington NHS
Addiction Sciences Building
4 Windsor Walk
Camberwell
SE5 8AF

Dear Miss Corno

Study title: **Familial Expressed Emotion (EE) as an Influence on Child Post-Traumatic Stress Disorder (PTSD)**
REC reference: **11/LO/0303**

Thank you for your letter of 31 May 2011, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation [as revised], subject to the conditions specified below.

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS sites

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Covering Letter		01 March 2011
Evidence of insurance or indemnity		09 July 2010
Investigator CV		01 February 2011
Other: CV: Dr Sean Perrin		01 March 2009
Participant Consent Form: Parent - appended to PIS	2	16 May 2011
Participant Consent Form: Child/Young person - appended to PIS	2	16 May 2011
Participant Consent Form: Adolescent - appended to PIS	3	21 June 2011
Participant Information Sheet: Parent	2	16 May 2011
Participant Information Sheet: Child/Young person	2	16 May 2011
Participant Information Sheet: Adolescent	3	21 June 2011
Protocol	4	27 May 2011
Questionnaire: Method For Rating FMSS		01 January 1986
Questionnaire: HADS Questionnaire		04 March 2011
Questionnaire: PDS Questionnaire		04 March 2011
Questionnaire: Screen for Child Anxiety Related Disorders (SCARED) - Child		04 March 2011
Questionnaire: Screen for Child Anxiety Related Disorders (SCARED) - Parent		04 March 2011
Questionnaire: Short Mood and Feelings Questionnaire (Child)		01 January 1987
Questionnaire: Short Mood and Feelings Questionnaire (Parent)		01 January 1987
Questionnaire: Children's PTSD Symptom Scale		01 January 2001
Questionnaire: Questionnaire: How I've been thinking and feeling since the frightening event		01 January 2003
Questionnaire: PTSD / Acute Stress Disorder (Child)		04 March 2011
Questionnaire: PTSD / Acute Stress Disorder (Parent)		04 March 2011
Questionnaire: Family Relationships Questionnaire - Child Version	5	31 January 2011
Questionnaire: Family Relationships Questionnaire - Parent Version	5	31 January 2011

Questionnaire: Family Environment Scale Form R		04 March 2011
REC application	3.1	04 March 2011
Referees or other scientific critique report		26 October 2010
Response to Request for Further Information: from Federica Corno		31 May 2011

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

Notifying substantial amendments
Adding new sites and investigators
Progress and safety reports
Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

11/LO/0303	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project

Yours sincerely

Mr John Richardson
Chair

Email: charis.bailey@eoe.nhs.uk

Institute of Psychiatry

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KING'S College LONDON *Founded 1829*

Miss Federica Corno
PO48 Institute of Psychiatry
De Crespigny Park
London
SE5 8AF

7 September 2011

Dear Miss Corno

Trust Approval: R&D2011/064 Familial expressed emotion (EE) as an influence on child posttraumatic stress disorder (PTSD)

I am writing to confirm approval for the above research project at South London and Maudsley NHS Foundation Trust. This approval relates to work in the Child and Adolescent Mental Health CAG and to the specific protocol and informed consent procedures described in your R&D Form. Any deviation from this document will be deemed to invalidate this approval. Your approval number has been quoted above and should be used at all times when contacting this office about this project.

Amendments, including extending to other Trust directorates will require further approval from this Trust and where appropriate the relevant Research Ethics Committee. Amendments should be submitted to this R&D Office by completion of an R&D Amendment form together with any supporting documents. A copy of this is attached but is also available on the R&D Office website.
http://www.iop.kcl.ac.uk/iopweb/blob/downloads/locator/l_314_RD_Approval_Amendment_Form_V2.doc

I can confirm that King's College London will be taking on the role of Sponsor for this study.

Approval is provided on the basis that you agree to adhere to the Department of Health's Research Governance requirements including:

- Ethical approval must be in place prior to the commencement of this project.
- As Chief Investigator and/or Principal Investigator for this study you have familiarised yourself with, and accept the responsibilities commensurate with this position, as outlined in the Research Governance Framework
- (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4122427.pdf).

South London and Maudsley NHS
NHS Foundation Trust

- Compliance with all policies and procedures of the Trust which relate to research, and with all relevant requirements of the Research Governance Framework. In particular the Trust Confidentiality Policy. http://www.iop.kcl.ac.uk/iopweb/blob/downloads/locator/l_313_SLaM_Confidentiality_Policy_v4.pdf

- Co-operating with the Trust R&D Office's regular monitoring and auditing of all approved research projects as required by the research governance framework, including complying with ad hoc requests for information.

- Informing the Trust's Health and Safety Coordinators and/or the Complaints Department or of any adverse events or complaints, from participants recruited from within this Trust, which occurs in relation to this study in line with Trust policies. Contact details are available from the R&D Office if required.

- Sending a copy of any reports or publications which result from this study to the Trust Departments involved in the study if requested.

- Honorary Contracts must be in place prior to patient contact for all relevant members of the research team. Advice on this will be provided by the R&D Office at the point of obtaining R&D approval and on an ongoing basis for new members of staff joining the research team.

- Sending a copy of the annual reports and end of project notification submitted to ethics.

Failure to abide by the above requirements may result in the withdrawal of the Trust's approval for this research.

If you wish to discuss any aspect of this research approval with the R&D Office, please contact Jenny Liebscher jennifer.liebscher@kcl.ac.uk in the first instance.

I wish you every success with this study.

Yours sincerely

Jenny Liebscher
R&D Governance and Delivery Manager
SLaM/IoP R&D Office

Enc. R&D Approval Amendment Form

APPENDIX 2: POST-TRAUMATIC STRESS DIAGNOSTIC SCALE (PDS)

Name: _____ **Date:** _____

PDS

Please answer the following questions in relation to **your own feelings** as a result of the traumatic event that your child experienced…

(15) **How long ago did the traumatic event happen? (circle ONE)**

1 Less than 1 month
2 1 to 3 months
3 3 to 6 months
4 6 months to 3 years
5 3 to 5 years
6 More than 5 years

For the following questions, circle Y for Yes, or N for No.

During this traumatic event:

(16) Y N Were you physically injured?
(17) Y N Was someone else physically injured?
(18) Y N Did you think that your life was in danger?
(19) Y N Did you think that someone else's life was in danger?
(20) Y N Did you feel helpless?
(21) Y N Did you feel terrified?

Below is a list of problems that people sometimes have after experiencing a traumatic event. Read each one carefully and circle the number (0-3) that best describes how often that problem has bothered you IN THE PAST MONTH. Rate each problem with respect to the traumatic event your child experienced.

0 Not at all or only one time
1 Once a week or less/once in a while
2 2 to 4 times a week/half the time
3 5 or more times a week/almost always

(22) 0 1 2 3 Having upsetting thoughts or images about the traumatic event that came into your head when you didn't want them to
(23) 0 1 2 3 Having bad dreams or nightmares about the traumatic event
(24) 0 1 2 3 Reliving the traumatic event, acting or feeling as if it was happening again
(25) 0 1 2 3 Feeling emotionally upset when you were reminded of the traumatic event (for example, feeling scared, angry, sad, guilty, etc.)
(26) 0 1 2 3 Experiencing physical reactions when you were reminded of the traumatic event (for example, breaking out in a sweat, heart beating fast)
(27) 0 1 2 3 Trying not to think about, talk about, or have feelings about the traumatic event
(28) 0 1 2 3 Trying to avoid activities, people, or places that remind you of the traumatic event
(29) 0 1 2 3 Not being able to remember an important part of the traumatic event
(30) 0 1 2 3 Having much less interest or participating much less often in important activities
(31) 0 1 2 3 Feeling distant or cut off from people around you
(32) 0 1 2 3 Feeling emotionally numb (for example, being unable to cry or unable to have loving feelings)
(33) 0 1 2 3 Feeling as if your future plans or hopes will not come true (for example, you will not have a career, marriage, children, or a long life
(34) 0 1 2 3 Having trouble falling or staying asleep
(35) 0 1 2 3 Feeling irritable or having fits of anger
(36) 0 1 2 3 Having trouble concentrating (for example, drifting in and out of conversation, losing track of a story on television, forgetting what you read)
(37) 0 1 2 3 Being overly alert (for example, checking to see who is around you, being uncomfortable with your back to a door, etc.)
(38) 0 1 2 3 Being jumpy or easily startled (for example, when someone walks up behind you)

---

(39) How long have you been experiencing the problems that you reported above? (circle ONE)

1 Less than 1 month
2 1 to 3 months
3 More than 3 months

(40) How long after the traumatic event did these problems begin? (circle ONE)

1 Less than 6 months

2 6 or more months

PLEASE TURN OVER...

Indicate below if the problems you rated above have interfered with any of the following areas of your life DURING THE PAST MONTH.
Circle Y for Yes and N for No.

(41)	Y	N	Work
(42)	Y	N	Household chores and duties
(43)	Y	N	Relationships with friends
(44)	Y	N	Fun and leisure activities
(45)	Y	N	Schoolwork
(46)	Y	N	Relationships with your family
(47)	Y	N	Sex life
(48)	Y	N	General satisfaction with life
(49)	Y	N	Overall level of functioning in all areas of your life

Hospital Anxiety and Depression Scale (HADS)

Patients are asked to choose one response from the four given for each interview. They should give an immediate response and be dissuaded from thinking too long about their answers. The questions relating to anxiety are marked "A", and to depression "D". The score for each answer is given in the right column. Instruct the patient to answer how it currently describes their feelings.

A	**I feel tense or 'wound up':**	
	Most of the time	3
	A lot of the time	2
	From time to time, occasionally	1
	Not at all	0

D	**I still enjoy the things I used to enjoy:**	
	Definitely as much	0
	Not quite so much	1
	Only a little	2
	Hardly at all	3

A	**I get a sort of frightened feeling as if something awful is about to happen:**	
	Very definitely and quite badly	3
	Yes, but not too badly	2
	A little, but it doesn't worry me	1
	Not at all	0

D	**I can laugh and see the funny side of things:**	
	As much as I always could	0
	Not quite so much now	1
	Definitely not so much now	2
	Not at all	3

A	**Worrying thoughts go through my mind:**	
	A great deal of the time	3
	A lot of the time	2
	From time to time, but not too often	1
	Only occasionally	0

D	**I feel cheerful:**	
	Not at all	3
	Not often	2
	Sometimes	1
	Most of the time	0

A	**I can sit at ease and feel relaxed:**	
	Definitely	0
	Usually	1
	Not Often	2
	Not at all	3

D	**I feel as if I am slowed down:**	
	Nearly all the time	3
	Very often	2
	Sometimes	1
	Not at all	0

A	**I get a sort of frightened feeling like 'butterflies' in the stomach:**	
	Not at all	0
	Occasionally	1
	Quite Often	2
	Very Often	3

D	**I have lost interest in my appearance:**	
	Definitely	3
	I don't take as much care as I should	2
	I may not take quite as much care	1
	I take just as much care as ever	0

A	**I feel restless as I have to be on the move:**	
	Very much indeed	3
	Quite a lot	2

	Not very much	1
	Not at all	0

D	**I look forward with enjoyment to things:**	
	As much as I ever did	0
	Rather less than I used to	1
	Definitely less than I used to	2
	Hardly at all	3

A	**I get sudden feelings of panic:**	
	Very often indeed	3
	Quite often	2
	Not very often	1
	Not at all	0

D	**I can enjoy a good book or radio or TV program:**	
	Often	0
	Sometimes	1
	Not often	2
	Very seldom	3

APPENDIX 4: SCREEN FOR CHILD ANXIETY RELATED DISORDERS – PARENT (SCARED-P)

Screen for Child Anxiety Related Disorders (SCARED)
Parent Version—Pg. 1 of 2 (To be filled out by the PARENT)

Name: _____

Date: _____

Directions:
Below is a list of statements that describe how people feel. Read each statement carefully and decide if it is "Not True or Hardly Ever True" or "Somewhat True or Sometimes True" or "Very True or Often True" for your child. Then for each statement, fill in one circle that corresponds to the response that seems to describe your child for the last 3 months. Please respond to all statements as well as you can, even if some do not seem to concern your child.

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True
1. When my child feels frightened, it is hard for him/her to breathe.	○	○	○
2. My child gets headaches when he/she is at school.	○	○	○
3. My child doesn't like to be with people he/she doesn't know well.	○	○	○
4. My child gets scared if he/she sleeps away from home.	○	○	○
5. My child worries about other people liking him/her.	○	○	○
6. When my child gets frightened, he/she feels like passing out.	○	○	○
7. My child is nervous.	○	○	○
8. My child follows me wherever I go.	○	○	○
9. People tell me that my child looks nervous.	○	○	○
10. My child feels nervous with people he/she doesn't know well.	○	○	○
11. My child gets stomachaches at school.	○	○	○
12. When my child gets frightened, he/she feels like he/she is going crazy.	○	○	○
13. My child worries about sleeping alone.	○	○	○
14. My child worries about being as good as other kids.	○	○	○
15. When he/she gets frightened, he/she feels like things are not real.	○	○	○
16. My child has nightmares about something bad happening to his/her parents.	○	○	○
17. My child worries about going to school.	○	○	○
18. When my child gets frightened, his/her heart beats fast.	○	○	○
19. He/she gets shaky.	○	○	○
20. My child has nightmares about something bad happening to him/her.	○	○	○

Screen for Child Anxiety Related Disorders (SCARED)

Parent Version—Pg. 2 of 2 (To be filled out by the PARENT)

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True
21. My child worries about things working out for him/her.	○	○	○
22. When my child gets frightened, he/she sweats a lot.	○	○	○
23. My child is a worrier.	○	○	○
24. My child gets really frightened for no reason at all.	○	○	○
25. My child is afraid to be alone in the house.	○	○	○
26. It is hard for my child to talk with people he/she doesn't know well.	○	○	○
27. When my child gets frightened, he/she feels like he/she is choking.	○	○	○
28. People tell me that my child worries too much.	○	○	○
29. My child doesn't like to be away from his/her family.	○	○	○
30. My child is afraid of having anxiety (or panic) attacks.	○	○	○
31. My child worries that something bad might happen to his/her parents.	○	○	○
32. My child feels shy with people he/she doesn't know well.	○	○	○
33. My child worries about what is going to happen in the future.	○	○	○
34. When my child gets frightened, he/she feels like throwing up.	○	○	○
35. My child worries about how well he/she does things.	○	○	○
36. My child is scared to go to school.	○	○	○
37. My child worries about things that have already happened.	○	○	○
38. When my child gets frightened, he/she feels dizzy.	○	○	○
39. My child feels nervous when he/she is with other children or adults and he/she has to do something while they watch him/her (for example: read aloud, speak, play a game, play a sport.)	○	○	○
40. My child feels nervous when he/she is going to parties, dances, or any place where there will be people that he/she doesn't know well.	○	○	○
41. My child is shy.	○	○	○

SCORING:

A total score of ≥ **25** may indicate the presence of an **Anxiety Disorder**. Scores higher than 30 are more specific.

A score of **7** for items 1, 6, 9, 12, 15, 18, 19, 22, 24, 27, 30, 34, 38 may indicate **Panic Disorder** or **Significant Somatic Symptoms**.

A score of **9** for items 5, 7, 14, 21, 23, 28, 33, 35, 37 may indicate **Generalized Anxiety Disorder**.

A score of **5** for items 4, 8, 13, 16, 20, 25, 29, 31 may indicate **Separation Anxiety Disorder**.

A score of **8** for items 3, 10, 26, 32, 39, 40, 41 may indicate **Social Anxiety Disorder**.

A score of **3** for items 2, 11, 17, 36 may indicate **Significant School Avoidance**.

Developed by Boris Birmaher, M.D., Suneeta Khetarpal, M.D., Marlane Cully, M.Ed., David Brent M.D., and Sandra McKenzie, Ph.D., Western Psychiatric Institute and Clinic, University of Pgh. (10/95). E-mail: birmaherb@msx.upmc.edu

APPENDIX 5: SHORT MOOD AND FEELINGS QUESTIONNAIRE – PARENT (SMFQ-P)

Parent-report version

SHORT MOOD AND FEELINGS QUESTIONNAIRE

This form is about how your child may have been feeling or acting recently.

For each question, please check how much she or he has felt or acted this way *in the past two weeks.*

If a sentence was true about your child most of the time, check TRUE.
If it was only sometimes true, check SOMETIMES.
If a sentence was not true about your child, check NOT TRUE.

		TRUE	SOME TIMES	NOT TRUE
1.	S/he felt miserable or unhappy	☐	☐	☐
2.	S/he didn't enjoy anything at all	☐	☐	☐
3.	S/he felt so tired that s/he just sat around and did nothing.	☐	☐	☐
4.	S/he was very restless	☐	☐	☐
5.	S/he felt s/he was no good any more	☐	☐	☐
6.	S/he cried a lot	☐	☐	☐
7.	S/he found it hard to think properly or concentrate	☐	☐	☐
8.	S/he hated him/herself	☐	☐	☐
9.	S/he felt s/he was a bad person	☐	☐	☐
10.	S/he felt lonely	☐	☐	☐
11.	S/he thought nobody really loved him/her	☐	☐	☐
12.	S/he thought s/he could never be as good as other kids	☐	☐	☐
13.	S/he felt s/he did everything wrong	☐	☐	☐

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APPENDIX 6: FAMILY ENVIRONMENT SCALE (FES)

TO BE COMPLETED BY PARENT

FAMILY ENVIRONMENT SCALE
FORM R

Item Booklet

Rudolf H Moos

Published by Mind Garden, Inc.
Info@mindgarden.com
www.mindgarden.com

Instructions

There are 90 statements in this booklet. They are statements about families. You are to decide which of these statements are true of your family and which are false. If you think the statement is *True* or mostly *True* of your family, make an X in the column labelled True. If you think the statement is *False* or mostly *False* of your family, make an X in the column labelled False.

You may feel that some of the statements are true for some family members and false for others. Mark True if the statement is true of most members. Mark False if the statement is false for most members. If the members are evenly divided, decide what is the stronger overall impression and answer accordingly.

Remember, we would like to know what your family seems like to you. So do not try to figure out how other members see your family, but do give us your general impression of your family for each statement.

TO BE COMPLETED BY PARENT

		True	False
1	Family members really help and support one another	☐	☐
2	Family members often keep their feelings to themselves	☐	☐
3	We fight a lot in our family	☐	☐
4	We don't do things on our own very often in our family	☐	☐
5	We feel it is important to be the best at whatever you do	☐	☐
6	We often talk about political and social problems	☐	☐
7	We spend most weekends and evenings at home	☐	☐
8	Family members attend church, synagogue, or Sunday school fairly often	☐	☐
9	Activities in our family are pretty carefully planned	☐	☐
10	Family members are rarely ordered around	☐	☐
11	We often seem to be killing time at home	☐	☐
12	We say anything we want to around home	☐	☐
13	Family members rarely become openly angry	☐	☐
14	In our family, we are strongly encouraged to be independent	☐	☐
15	Getting ahead in life is very important in our family	☐	☐
16	We rarely go to lectures, plays or concerts	☐	☐
17	Friends often come over for dinner or to visit	☐	☐
18	We don't say prayers in our family	☐	☐
19	We are generally very neat and orderly	☐	☐
20	There are very few rules to follow in our family	☐	☐
21	We put a lot of energy into what we do at home	☐	☐
22	It's hard to "blow off stem" at home without upsetting somebody	☐	☐
23	Family members sometimes get so angry they throw things	☐	☐
24	We think things out for ourselves in our family	☐	☐
25	How much money a person makes is not very important to us	☐	☐
26	Learning about new and different things is very important in our family	☐	☐
27	Nobody in our family is active in sports, Little League, bowling etc	☐	☐
28	We often talk about the religious meaning of Christmas, Passover, or other holidays	☐	☐
29	It's often hard to find things when you need them in our household	☐	☐
30	There is one family member who makes most of the decisions	☐	☐
31	There is a feeling of togetherness in our family	☐	☐
32	We tell each other about our personal problems	☐	☐
33	Family member hardly ever lose their tempers	☐	☐
34	We come and go as we want to in our family	☐	☐
35	We believe in competition and "may the best man win"	☐	☐
36	We are not interested in cultural activities	☐	☐
37	We often go to the movies, sports events, camping etc	☐	☐
38	We don't believe in heaven and hell	☐	☐

TO BE COMPLETED BY PARENT

		True	False
39	Being on time is very important in our family	☐	☐
40	There are set ways of doing things at home	☐	☐
41	We rarely volunteer when something has to be done at home	☐	☐
42	If we feel like doing something on the spur of the moment we often just pick up and go	☐	☐
43	Family members often criticise each other	☐	☐
44	There is very little privacy in our family	☐	☐
45	We always strive to do things just a little better the next time	☐	☐
46	We rarely have intellectual discussions	☐	☐
47	Everyone in our family has a hobby or two	☐	☐
48	Family members have strict ideas about what is right and wrong	☐	☐
49	People change their minds often in our family	☐	☐
50	There is a strong emphasis on following rules in our family	☐	☐
51	Family members really back each other up	☐	☐
52	Someone usually gets upset if you complain in our family	☐	☐
53	Family members sometimes hit each other	☐	☐
54	Family members almost always rely on themselves when a problem comes up	☐	☐
55	Family members rarely worry about job promotions, school grades etc	☐	☐
56	Someone in our family plays a musical instrument	☐	☐
57	Family members are not very involved in recreational activities outside work or school	☐	☐
58	We believe there are some things you just have to take on faith	☐	☐
59	Family members make sure their rooms are neat	☐	☐
60	Everyone has an equal say in family decisions	☐	☐
61	There is very little group spirit in our family	☐	☐
62	Money and paying bills is openly talked about in our family	☐	☐
63	If there's a disagreement in our family, we try hard to smooth things over and keep the peace	☐	☐
64	Family members strongly encourage each other to stand up for their rights	☐	☐
65	In our family, we don't try that hard to succeed	☐	☐
66	Family members often go to the library	☐	☐
67	Family members sometimes attend courses or take lessons for some hobby or interest (outside of school)	☐	☐
68	In our family each person has different ideas about what is right wrong	☐	☐
69	Each person's duties are clearly defined in our family	☐	☐
70	We can do whatever we want to in our family	☐	☐
71	We really get along well with each other	☐	☐
72	We are usually careful about what we say to each other	☐	☐
73	Family members often try to one-up or out-do each other	☐	☐

TO BE COMPLETED BY PARENT

		True	False
74	It's hard to be by yourself without hurting someone's feelings in our household	☐	☐
75	"Work before play" is a rule in our family	☐	☐
76	Watching TV is more important than reading in our family	☐	☐
77	Family members go out a lot	☐	☐
78	The Bible is a very important book in our home	☐	☐
79	Money is not handled very carefully in our family	☐	☐
80	Rules are pretty flexible in our household	☐	☐
81	There is plenty of time and attention for everyone in our family	☐	☐
82	There are a lot of spontaneous discussions in our family	☐	☐
83	In our family, we believe you don't ever get anywhere by raising your voice	☐	☐
84	We are not really encouraged to speak up for ourselves in our family	☐	☐
85	Family members are often compared with others as to how well they are doing at work or school	☐	☐
86	Family members really like music, art and literature	☐	☐
87	Our main form of entertainment is watching TV or listening to the radio	☐	☐
88	Family members believe that if you sin you will be punished	☐	☐
89	Dishes are usually done immediately after eating	☐	☐
90	You can't get away with much in our family	☐	☐

APPENDIX 7: CHILD PTSD SYMPTOM SCALE (CPSS)

Children's PTSD Symptom Scale

Name: _____ **Date:** _____

Below is a list of problems that children and young people sometimes have after experiencing an upsetting event. Read each one carefully and circle the number (0–3) that best describes how often that problem has bothered you in the last week.

0	1	2	3
Not at all or only one time	Once a week or less/once in a while	2 to 4 times a week/half the time	5 or more times a week/almost always

(1) 0 1 2 3 Having upsetting thoughts or images about the event that came into your head when you didn't want them to

(2) 0 1 2 3 Having bad dreams or nightmares

(3) 0 1 2 3 Acting or feeling as if the event was happening again (hearing something or seeing a picture about it and feeling as if I am there again)

(4) 0 1 2 3 Feeling upset when you think or hear about the event (for example, feeling scared, angry, sad, guilty etc)

(5) 0 1 2 3 Having feelings in your body when you think about or hear about the event (for example, breaking out in a sweat, heart beating fast)

(6) 0 1 2 3 Trying not to think about, talk about, or have feelings about the event

(7) 0 1 2 3 Trying to avoid activities, people, or places that remind you of the traumatic event

(8) 0 1 2 3 Not being able to remember an important part of the upsetting event

Please turn over

0	1	2	3
Not at all or only one time	Once a week or less/once in a while	2 to 4 times a week/half the time	5 or more times a week/almost always

(9) 0 1 2 3 Having much less interest or not doing the things you used to do

(10) 0 1 2 3 Not feeling close to people around you

(11) 0 1 2 3 Not being able to have strong feelings (for example, being unable to cry or unable to feel very happy)

(12) 0 1 2 3 Feeling as if your future plans or hopes will not come true (for example, you will not have a job or get married or have kids)

(13) 0 1 2 3 Having trouble falling or staying asleep

(14) 0 1 2 3 Feeling irritable or having fits of anger

(15) 0 1 2 3 Having trouble concentrating (for example, losing track of a story on television, forgetting what you read, not paying attention in class)

(16) 0 1 2 3 Being overly careful (for example, checking to see who is around you and what is around you)

(17) 0 1 2 3 Being jumpy or easily startled (for example, when someone walks up behind you)

Please indicate below if the problems you rated above have got in the way of any of the following areas of your life during the past week. Circle Y for Yes, N for No.

(18) Y N Fun and hobby activities

(19) Y N Relationships with your friends

(20) Y N Schoolwork

(21) Y N Relationship with your family

(22) Y N Chores and duties at home

(23) Y N General happiness with your life

APPENDIX 8: CHILD POST-TRAUMATIC COGNITIONS INVENTORY (cPTCI)

Name: _____ Date: _____

How I've been thinking and feeling since the frightening event

We would like to know what kinds of thoughts and feelings you've been having after the frightening event. Below is a list of statements. Please read each statement carefully and tell us how much you AGREE or DISAGREE with each statement by ticking one box. People react to frightening events in many different ways. There are no right or wrong answers to these statements.

	Don't agree at all	Don't agree a bit	Agree a bit	Agree a lot
1. Anyone could hurt me.	[ ]	[ ]	[ ]	[ ]
2. Everyone lets me down.	[ ]	[ ]	[ ]	[ ]
3. I am a coward.	[ ]	[ ]	[ ]	[ ]
4. My reactions since the frightening event mean I have changed for the worse.	[ ]	[ ]	[ ]	[ ]
5. I don't trust people.	[ ]	[ ]	[ ]	[ ]
6. My reactions since the frightening event mean something is seriously wrong with me.	[ ]	[ ]	[ ]	[ ]
7. I am no good.	[ ]	[ ]	[ ]	[ ]
8. Not being able to get over all my fears means that I am a failure.	[ ]	[ ]	[ ]	[ ]
9. Small things upset me.	[ ]	[ ]	[ ]	[ ]
10. I can't cope when things get tough.	[ ]	[ ]	[ ]	[ ]
11. I can't stop bad things from happening to me.	[ ]	[ ]	[ ]	[ ]
12. I have to watch out for danger all the time.	[ ]	[ ]	[ ]	[ ]
13. My reactions since the frightening event mean I will never get over it.	[ ]	[ ]	[ ]	[ ]
14. I used to be a happy person but now I am always sad.	[ ]	[ ]	[ ]	[ ]
15. Bad things always happen.	[ ]	[ ]	[ ]	[ ]
16. I will never be able to have normal feelings again.	[ ]	[ ]	[ ]	[ ]
17. I'm scared that I'll get so angry that I'll break something or hurt someone.	[ ]	[ ]	[ ]	[ ]
18. Life is not fair.	[ ]	[ ]	[ ]	[ ]
19. My life has been destroyed by the frightening event.	[ ]	[ ]	[ ]	[ ]
20. I feel like I am a different person since the frightening event.	[ ]	[ ]	[ ]	[ ]
21. My reactions since the frightening event show that I must be going crazy.	[ ]	[ ]	[ ]	[ ]
22. Nothing good can happen to me anymore.	[ ]	[ ]	[ ]	[ ]
23. Something terrible will happen if I do not try to control my thoughts about the frightening event.	[ ]	[ ]	[ ]	[ ]
24. The frightening event has changed me forever.	[ ]	[ ]	[ ]	[ ]
25. I have to be really careful because something bad could happen.	[ ]	[ ]	[ ]	[ ]

APPENDIX 9: SCREEN FOR CHILD ANXIETY DISORDERS – CHILD (SCARED-C)

Screen for Child Anxiety Related Disorders (SCARED)
Child Version—Pg. 1 of 2 (To be filled out by the CHILD)

Name: _____

Date: _____

Directions:
Below is a list of sentences that describe how people feel. Read each phrase and decide if it is "Not True or Hardly Ever True" or "Somewhat True or Sometimes True" or "Very True or Often True" for you. Then for each sentence, fill in one circle that corresponds to the response that seems to describe you for the last 3 months.

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True
1. When I feel frightened, it is hard to breathe.	○	○	○
2. I get headaches when I am at school.	○	○	○
3. I don't like to be with people I don't know well.	○	○	○
4. I get scared if I sleep away from home.	○	○	○
5. I worry about other people liking me.	○	○	○
6. When I get frightened, I feel like passing out.	○	○	○
7. I am nervous.	○	○	○
8. I follow my mother or father wherever they go.	○	○	○
9. People tell me that I look nervous.	○	○	○
10. I feel nervous with people I don't know well.	○	○	○
11. I get stomachaches at school.	○	○	○
12. When I get frightened, I feel like I am going crazy.	○	○	○
13. I worry about sleeping alone.	○	○	○
14. I worry about being as good as other kids.	○	○	○
15. When I get frightened, I feel like things are not real.	○	○	○
16. I have nightmares about something bad happening to my parents.	○	○	○
17. I worry about going to school.	○	○	○
18. When I get frightened, my heart beats fast.	○	○	○
19. I get shaky.	○	○	○
20. I have nightmares about something bad happening to me.	○	○	○

Screen for Child Anxiety Related Disorders (SCARED)

Child Version—Pg. 2 of 2 (To be filled out by the CHILD)

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True
21. I worry about things working out for me.	○	○	○
22. When I get frightened, I sweat a lot.	○	○	○
23. I am a worrier.	○	○	○
24. I get really frightened for no reason at all.	○	○	○
25. I am afraid to be alone in the house.	○	○	○
26. It is hard for me to talk with people I don't know well.	○	○	○
27. When I get frightened, I feel like I am choking.	○	○	○
28. People tell me that I worry too much.	○	○	○
29. I don't like to be away from my family.	○	○	○
30. I am afraid of having anxiety (or panic) attacks.	○	○	○
31. I worry that something bad might happen to my parents.	○	○	○
32. I feel shy with people I don't know well.	○	○	○
33. I worry about what is going to happen in the future.	○	○	○
34. When I get frightened, I feel like throwing up.	○	○	○
35. I worry about how well I do things.	○	○	○
36. I am scared to go to school.	○	○	○
37. I worry about things that have already happened.	○	○	○
38. When I get frightened, I feel dizzy.	○	○	○
39. I feel nervous when I am with other children or adults and I have to do something while they watch me (for example: read aloud, speak, play a game, play a sport.)	○	○	○
40. I feel nervous when I am going to parties, dances, or any place where there will be people that I don't know well.	○	○	○
41. I am shy.	○	○	○

SCORING:

A total score of ≥ **25** may indicate the presence of an **Anxiety Disorder**. Scores higher that 30 are more specific.

A score of **7** for items 1, 6, 9, 12, 15, 18, 19, 22, 24, 27, 30, 34, 38 may indicate **Panic Disorder** or **Significant Somatic Symptoms**.

A score of **9** for items 5, 7, 14, 21, 23, 28, 33, 35, 37 may indicate **Generalized Anxiety Disorder**.

A score of **5** for items 4, 8, 13, 16, 20, 25, 29, 31 may indicate **Separation Anxiety Disorder**.

A score of **8** for items 3, 10, 26, 32, 39, 40, 41 may indicate **Social Anxiety Disorder**.

A score of **3** for items 2, 11, 17, 36 may indicate **Significant School Avoidance**.

**For children ages 8 to 11, it is recommended that the clinician explain all questions, or have the child answer the questionnaire sitting with an adult in case they have any questions.*

Developed by Boris Birmaher, M.D., Suneeta Khetarpal, M.D., Marlane Cully, M.Ed., David Brent M.D., and Sandra McKenzie, Ph.D., Western Psychiatric Institute and Clinic, University of Pgh. (10/95). E-mail: birmaherb@msx.upmc.edu

APPENDIX 10: SHORT MOOD AND FEELINGS QUESTIONNAIRE – CHILD (SMFQ-C)

Self-report version

SHORT MOOD AND FEELINGS QUESTIONNAIRE

This form is about how you might have been feeling or acting recently.

For each question, please check how much you have felt or acted this way *in the past two weeks*.

If a sentence was true about you most of the time, check TRUE.
If it was only sometimes true, check SOMETIMES.
If a sentence was not true about you, check NOT TRUE.

		TRUE	SOME TIMES	NOT TRUE
1.	I felt miserable or unhappy	☐	☐	☐
2.	I didn't enjoy anything at all	☐	☐	☐
3.	I felt so tired I just sat around and did nothing	☐	☐	☐
4.	I was very restless	☐	☐	☐
5.	I felt I was no good any more	☐	☐	☐
6.	I cried a lot	☐	☐	☐
7.	I found it hard to think properly or concentrate	☐	☐	☐
8.	I hated myself	☐	☐	☐
9.	I was a bad person	☐	☐	☐
10.	I felt lonely	☐	☐	☐
11.	I thought nobody really loved me	☐	☐	☐
12.	I thought I could never be as good as other kids	☐	☐	☐
13.	I did everything wrong	☐	☐	☐

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APPENDIX 11: TALKING ABOUT TRAUMA QUESTIONNAIRE - CHILD AND PARENT VERSIONS (TATQ-C and TATQ-P)

Child version

Question	**True /Often**	**Sometimes True/ Sometimes**	**Not True/ Never**
It's really hard for me to talk to mum / dad about what happened			
I don't really want to talk to mum / dad about what happened			
Talking to mum / dad about what happened makes me really upset			
Talking to mum / dad about what happened makes her / him really upset			
I don't want mum / dad to be reminded of what happened			
I don't want mum / dad to remind me of what happened			
I am afraid of upsetting my mum / dad by talking about what happened			
I am afraid of my mum / dad seeing me upset			
When I see my mum / dad get upset I think it is all my fault			
I get really angry when I talk to mum / dad about what happened			
Mum / Dad gets angry when I talk to her / him about what happened			
I get really anxious when I talk to mum / dad about what happened			
Mum / Dad gets anxious when I talk to her / him about what happened			
Talking to mum / dad helps me feel better			
Talking to mum / dad helps her / him feel better			
Mum / Dad doesn't understand what it was for me			

Parent version

Question	True /Often	Sometimes True/ Sometimes	Not True/ Never
It's really hard for me to talk to my child about what happened			
I prefer not to talk to my child about what happened			
Talking to my child about what happened makes me really upset			
Talking to my child about what happened makes my child really upset			
I don't want my child to be reminded of what happened			
I don't want my child to remind me of what happened			
I am afraid of upsetting my child by asking him/her to talk about happened			
I am afraid to let my child see me get upset			
When I see my child get upset I think it is all my fault			
Talking to my child about what happened makes me really angry			
Talking to my child about what happened makes my child really angry			
Talking to my child about what happened makes me really anxious			
Talking to my child about what happened makes my child really anxious			
Talking to my child helps me feel better			
Talking to my child helps my child feel better			
It's difficult for me to understand what it was like for my child			

APPENDIX 12: FIVE MINUTES SPEECH SAMPLE – INSTRUCTIONS

I'd like to hear your thoughts and feelings about (child's name) in your own words and without my interrupting with any questions or comments. When I ask you to begin, I'd like you to speak for five minutes, telling me what kind of a person s/he is and how the two of you get along together. It may feel a little strange or weird at first, but there are no right or wrong answers. I'll let you know when 5 minutes has passed so try to keep talking until then. After you begin to speak, I prefer not to answer any questions until after the 5 minutes are over. Do you have any questions before we begin?

Give minimal eye contact. If necessary, give eye contact and prompt using the following neutral statements:

- Take your time / you've got a bit more time left.
- Anything else?

Keep the stopwatch going for five minutes and stop only if they are really struggling or refuse to continue.

APPENDIX 13: FIVE MINUTES SPEECH SAMPLE – SCORING SHEET

Rated by: Date rated: Participant Number: Parent:			Mother	Father
Initial Statement:		positive	neutral	negative
Quality of Relationship: code each statement				
	Overall rating:	positive	neutral	negative
Criticism:	Total number:			
Dissatisfaction:			Y	N
Total CRIT EE:		high	borderline	low
Emotional Over-involvement:				
Self-sacrificing/ overprotective			Y	N
Emotional display			Y	N
Excessive detail:			Y	N
Positive remarks	Total number: Excessive praise (5+)?		Y	N
Statements of attitude	Total number:			
Total EOI EE:		high	borderline	low
Other Notes				

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PARENT INFORMATION SHEET

Family interactions with children exposed to trauma

You and your child are being invited to take part in a research study which is part of an educational project (Doctorate in Clinical Psychology). Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and ask us if there is anything that is not clear or if you would like more information.

What is the purpose of the study?
This study is to help us understand more about the interactions within families of children who have been exposed to trauma. Previous research has shown that parents are affected by traumatic experiences that their children have been exposed to. Research has also shown that it is helpful to involve the families of children with post-traumatic stress disorder in the treatment that they receive. We want to find out more about parents' feeling about their children's traumatic experiences and family interactions with children who have had such experiences. This is a student project, which will form part of a doctoral thesis in clinical psychology.

Why have I been chosen?
In this study, we are inviting all families whose children are referred for an assessment and treatment of post-traumatic stress at the local and national specialist child and adolescent mental health services within South London and the Maudsley NHS Trust.

Do I have to take part?
No, it's up to you to decide whether or not to take part. If you do not want to take part, this will not affect the care you or your child receive from the service in any way. If you decide to take part you will be free to withdraw from the study at any time without giving a reason and this will not affect the care you receive from the service.

What will happen if I take part?
If you decided to take part you and your child will be asked to participate in the study at the clinic that you are receiving treatment from. You would be asked to keep this information sheet and to sign a consent form to say you agree to take part. You will also be asked to sign your child's consent form if they are under 16 years of age.

Once you have signed the consent forms, the researcher will ask you some questions about your child and your relationship since the trauma your child experienced. This part will be audio-taped and will take 5 minutes.

After this, the audio recorder will be stopped and you and your child will be asked to fill in some questionnaires about how both have been feeling since the trauma and in general. These should take approximately 20 minutes to complete.

What are the possible disadvantages of taking part?
Part of the study will involve you and your child filling in questionnaires about how you have both been thinking and feeling since the trauma. These questionnaires are often used at these clinics as part of routine assessment. Another part of the study will involve audio-taping you talking about your child and your relationship since the trauma happened for 5 minutes. This might involve talking about the trauma, which you or your child may find distressing, although talking about the trauma would be part of routine assessment anyway. If this brought up any concerns, you would have the opportunity to discuss them with the researcher, who is a clinical psychologist in training under the supervision of qualified clinical psychologists. You would also be able to talk to the clinical psychologist who is seeing your child at the clinic.

What are the possible benefits of taking part?
We hope that you will find it interesting to take part in this research and you will be offered a summary of our findings once the project is complete. The information we get from this study will help us to understand more about the nature of family interactions between parents and children who have been exposed to a trauma. This will help us to develop more understanding about how to involve families in the therapies we use in our services.

Will my taking part in this study be kept confidential?
All information which is collected about you and your child during the course of the research will be kept strictly confidential. You and your child will be given a participant number which will be attached to your information instead of your names, so it will be totally anonymous. The audio tapes will be kept securely in a locked office and will be destroyed at the end of the study.

What will happen to the results of the research study?
The findings of this study are likely to be published in a peer reviewed journal. No individual details will be reported and you or your child will not be identified in any report or publication.

Will I have a compensation for taking part in this study?
We would like to thank you and your child and reimburse you for your time with a £10 voucher.

For further information please contact Federica Corno.

Telephone: 07950558960
Email: federica.corno@kcl.ac.uk
Address: Department of Psychology
PO Box 78, ASB
Institute of Psychiatry
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Thank you for reading this information sheet

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CONSENT FORM - PARENT

Family interactions with children exposed to trauma

Federica Corno, Dr Sean Perrin and Dr Patrick Smith

	Please initial box
1. I confirm that I have read and understand the information sheet dated XX/XX/2011 for the above study and have had the opportunity to ask questions.	☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.	☐
3. I agree to take part in the above study.	☐

Name of Parent:	Date:	Signature:
…….	……..	……..
Researcher:	Date:	Signature:
…….	……..	……..

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Ethics Ref no: 11/LO/0303

CHILD'S INFORMATION SHEET

Family interactions with children exposed to scary events

Federica Corno, Dr Sean Perrin and Dr Patrick Smith

You and your parent are being invited to take part in a research study which is part of an educational project (Doctorate in Clinical Psychology). Before you decide it is important for you to understand why it is being done and what it will involve. Please take time to read the information carefully and ask us if there is anything that you do not understand or if you would like more information.

What is this study for?
This is a student project that will help us understand more about families of children and young people who have had scary events happen to them.

Why me?
In this study, we are inviting all the children and their parents who come for an assessment at the clinic because of a scary thing that happened to them, to take part in this study.

Do I have to take part?
No, it's up to you to decide whether or not to take part. If you do not want to take part, the care you or your parent receive from the clinic will not change in any way. If you decide not to take part you can still change your mind later and we will not ask you why. If you do not want to take part, we will not ask you why and this will not change the care you receive from the clinic.

What will happen if I take part?
If you decided to take part you will do the study when you and your parent come to the clinic. You would be asked to keep this information sheet and to sign a form to say that you agree to take part.

In the study, your parent will be asked some questions about you and your relationship since the scary event that happened to you, with you there. This part will be audio-taped and will take 5 minutes.

After this, the audio recorder will be stopped and you and your parent will be asked to fill in some questionnaires about how you are both feeling. These should take about 20 minutes to complete.

Are there any problems with taking part?
Part of the study will involve you and your parent filling in questionnaires about how you have both been thinking and feeling, but children and parents are often asked to do these questionnaires at our clinics anyway. Another part of the study will involve audio-taping your parent talking about you and your relationship for 5 minutes. This will mean possibly talking about the scary event, which you might find upsetting, although talking about what happened

is also something that we do at the clinic anyway. If the study made you feel worried about anything, you would be able to talk to the psychologists at the clinic.

What would be good about taking part?
We hope that you will find it interesting to take part. This study will help us to understand more about parents and children who have had a scary event happen to them. It will help us to think about how to involve families in the therapies we use in our clinic.

Will anyone else know about me taking part in this study?
All the information which is taken about you and your parent during the study will be confidential, which means that we will not give any of your personal information out to anybody. You and your parent will be given a number which will be attached to your information instead of your names, so it will be completely anonymous. The audio tapes will be kept in a locked office and will be destroyed at the end of the study.

Will I get a voucher to take part in this study?
We would like to thank you for your time with a £10 voucher.

If you have any questions or want to talk to me about the study, please contact me on the details below:

Federica Corno

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CONSENT FORM - CHILD

Family interactions with children exposed to scary events

Dr Sean Perrin, Dr Patrick Smith and Federica Corno

	Please initial box
1. I have read and understood the information sheet dated XX/XX/2011 for the above study and have been able to ask questions.	☐
2. I understand that I do not have to take part if I do not want to. If I decide to take part I can change my mind later and can stop the study any time without saying why. If I do not want to take part I will not be asked why.	☐
3. I agree to take part in the above study.	☐

Name of Child/Young Person:	Date:	Signature:
…….	……...	……..
Name of Parent (if Child under 16):	Date:	Signature:
…….	……...	……..
Researcher:	Date:	Signature:
…….	……...	……..

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SE5 8AF

Institute of Psychiatry

at The Maudsley

Ethics Ref no: 11/LO/0303

ADOLESCENT INFORMATION SHEET

Family interactions with children exposed to trauma

You and your parent are being invited to take part in a research study which is part of an educational project (Doctorate in Clinical Psychology). Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and ask us if there is anything that is not clear or if you would like more information.

What is the purpose of the study?
This study is to help us understand more about the interactions within families of children who have been exposed to trauma. Previous research has shown that parents are affected by traumatic experiences that their children have been exposed to. Research has also shown that it is helpful to involve the families of children with post-traumatic stress disorder in the treatment that they receive. We want to find out more about parents' feeling about their children's traumatic experiences and family interactions with children who have had such experiences. This is a student project, which will form part of a doctoral thesis in clinical psychology.

Why have I been chosen?
In this study, we are inviting all families whose children are referred for an assessment and treatment of post-traumatic stress at the local and national specialist child and adolescent mental health services within South London and the Maudsley NHS Trust.

Do I have to take part?
No, it's up to you to decide whether or not to take part. If you do not want to take part, this will not affect the care you receive from the service in any way. If you decide to take part you will be free to withdraw from the study at any time without giving a reason and this will not affect the care you receive from the service.

What will happen if I take part?
If you decided to take part you and your parent will be asked to participate in the study at the clinic that you are receiving treatment from. You would be asked to keep this information sheet and to sign a consent form to say you agree to take part.

Once you have signed the consent form, the researcher will ask your parent some questions about you and your relationship since the trauma you experienced. This part will be audio-taped and will take 5 minutes.

After this, the audio recorder will be stopped and you and your parent will be asked to fill in some questionnaires about how both have been feeling since the trauma and in general. These should take approximately 20 minutes to complete.

What are the possible disadvantages of taking part?
Part of the study will involve you and your parent filling in questionnaires about how you have both been thinking and feeling since the trauma. These questionnaires are often used at these clinics as part of routine assessment. Another part of the study will involve audio-taping your parent talking about you and your relationship since the trauma happened for 5 minutes. This might involve talking about the trauma, which you or your parent may find distressing, although talking about the trauma would be part of routine assessment anyway. If this brought up any concerns, you would have the opportunity to discuss them with the researcher, who is a clinical psychologist in training under the supervision of qualified clinical psychologists. You would also be able to talk to the clinical psychologist who is seeing you at the clinic.

What are the possible benefits of taking part?
We hope that you will find it interesting to take part in this research and you will be offered a summary of our findings once the project is complete. The information we get from this study will help us to understand more about the nature of family interactions between parents and children who have been exposed to a trauma. This will help us to develop more understanding about how to involve families in the therapies we use in our services.

Will my taking part in this study be kept confidential?
All information which is collected about you and your parent during the course of the research will be kept strictly confidential. You and your parent will be given a participant number which will be attached to your information instead of your names, so it will be totally anonymous. The audio tapes will be kept securely in a locked office and will be destroyed at the end of the study.

What will happen to the results of the research study?
The findings of this study are likely to be published in a peer reviewed journal. No individual details will be reported and you or your parent will not be identified in any report or publication.

Will I have a compensation for taking part in this study?
We would like to thank you and reimburse you for your time with a £10 voucher.

For further information please contact Federica Corno.

Telephone: 07950558960
Email: federica.corno@kcl.ac.uk
Address: Department of Psychology
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Institute of Psychiatry
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Thank you for reading this information sheet

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at The Maudsley

Ethics Ref no: 11/LO/0303

CONSENT FORM - ADOLESCENT

Family interactions with children exposed to trauma

Federica Corno, Dr Sean Perrin and Dr Patrick Smith

	Please initial box
1. I confirm that I have read and understand the information sheet dated 25/11/2011 for the above study and have had the opportunity to ask questions.	☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.	☐
3. I agree to take part in the above study.	☐

Name of Adolescent:	Date:	Signature:
…….	……..	……..
Researcher:	Date:	Signature:
…….	……..	……..

South London and Maudsley NHS
NHS Foundation Trust

National and Specialist CAMHS
Child Anxiety & Trauma Clinic
Michael Rutter Centre for Children and Young People
The Maudsley Hospital
De Crespigny Park
Denmark Hill
London SE5 8AZ
0203-228-2657

STUDY OF FAMILY INTERACTIONS IN CHILDREN EXPOSED TO TRAUMA

Ethics Ref no: 11/LO/0303 - Trust Approval: R&D2011/064

We are conducting a study to see if a child's traumatic reaction is related to the way emotion is expressed in the family. We are looking to recruit children & adolescents who are:

- **Aged 7-18 years of age**
- **Fluent in English**
- **Exposed to a traumatic event:**
  road traffic accidents, assaults, or other serious accidents
- **Have 1 or more PTSD symptoms:**
  - **Nightmares, flashbacks, unwanted thoughts of the trauma**
  - **Avoidance of traumatic reminders**
  - **Feeling numb or unable to have fun as before**
  - **Impaired sleep/concentration, exaggerated startle, irritability, hyper vigilance to danger**

Participants in the study will be asked to do a 5-minute speech sample and complete a few questionnaires about trauma-related symptoms

Participation in the study can be done at the local CAMHS or by arrangement with the family

If you have a family who might be suitable for the study or want further details about referral, please contact the clinic on 0203-228-2657 or write to either:

Federica Corno at: federica.corno@slam.nhs.uk
Dr Patrick Smith at: patrick.smith@slam.nhs.uk

PART 2

Service evaluation project

GUIDED SELF HELP BOOKS FOR ALCOHOL PROBLEMS

Federica Corno

Supervisor: Dr Tim Meynen

TABLE OF CONTENTS

ABSTRACT

Background

Alcohol consumption is associated with multiple poor outcomes. Interventions for alcohol misuse are effective, however, only about 6% people per year receive treatment. Guided self-help books have been shown to be an effective treatment in general adult mental health. The present study sought to explore the availability of self-help books and identify what is most applicable to alcohol and to make recommendations on how these could be used within a community alcohol treatment programme.

Methodology

Five alcohol self-help books were selected from a systematic review of 30 books. The five books were selected for their quality and their potential relevance to the treatment of alcohol. Reviewers recruited from the staff members, service users and their carers at the Greenwich Community Drug and Alcohol Team, were asked to read one or more of the selected books and provide comments as to the usefulness of the book in the treatment of alcohol. Reviewers' comments were collected using a specifically designed study questionnaire.

Findings

20 study questionnaires were completed (10 by staff members, 8 by service users, and 2 by carers) for the 5 selected books. 100% of reviewers thought that the books were over-all useful. The structural aspects of the book, whether the book generated hope in recovery, and a collaborative framework were crucial aspects across all the books.

Conclusions

Recommendations are proposed about how guided self-help books for alcohol problems could become a service standard that all service users are informed about across Greenwich Addiction and Adult Mental Health services.

1. BACKGROUND

1.1 SETTING THE SCENE

For a significant and growing number of people in England, alcohol consumption is a major cause of ill-health. Alcohol dependence affects 4% of people aged between 16 and 65 in England (6% of men and 2% of women); more than 10 million people, over 24% of the English population (33% of men and 16% of women), are now regularly drinking above the guidelines set by Government and consume alcohol in a way that is potentially or actually harmful to their health or well-being, and many of these are likely to suffer ill-health or injury as a result. Alcohol misuse is also an increasing problem in children and young people, with over 24,000 treated in the NHS for alcohol-related problems in 2008 and 2009 (Department of Health, DOH, 2008; NICE, 2011).

Hospital admissions for alcohol specific conditions (e.g. alcohol-related liver disease, mental health disorders linked to alcohol and acute intoxication) more than doubled in the 11 years between 1995-96 and 2006-07 from 93,459 to 207,788. There were 8,758 deaths from alcohol-related causes in the UK in 2006, twice as many as there were 15 years before. The DOH estimated in July 2008 that alcohol misuse costs the health service in the order of £2.7 billion per year. Such misuse also imposes wider costs on society, such as crime and disorder, social and family breakdown and sickness absence (DOH, 2008; NICE, 2011).

There is good evidence to show that interventions for alcohol misuse are effective, reducing the alcohol consumption of a proportion of people and mitigating the damage to their health (Raistrick et al, 2006). However, of the 1 million people aged between 16 and 65 who are alcohol dependent in England, only about 6% per year receive treatment (DOH, 2008). Reasons for this include the often long period between developing alcohol dependence and seeking help, and the limited availability of specialist alcohol treatment services in some parts of England. Additionally, alcohol misuse is under-identified by health and social care professionals, leading to missed opportunities to provide effective interventions (DOH, 2008).

Moreover, a majority of people with alcohol-related problems have relatively low levels of problem severity. For the most part, these people are not attracted to alcohol services that focus primarily on those with severe problems associated with dependency. Also,

given that problem severity in most problem drinkers is relatively low, providing regular treatment would in many cases be a waste of resources. Therefore, identifying effective, brief and accessible treatments for alcohol-related problems is an important research task, with important implications for public health.

1.2 THE 'STEPPED CARE' FRAMEWORK

To try and answer this issue, it is necessary to: a) provide the least restrictive and least costly intervention that will be effective for a person's presenting problems; and b) use a self-correcting mechanism to ensure that, if an individual does not benefit from an initial intervention, a system of monitoring is in place, so that a more appropriate and intensive intervention is identified and provided. These are the two key principles of the 'stepped care' approach to care (Davison, 2000; Sobell & Sobell, 2000), which has recently evolved and been increasingly adopted in the NHS (www.iapt.nhs.uk).

Stepped-care models provide for escalating levels of response to the complexity or severity of the disorder and are an explicit attempt to formalise the delivery and monitoring of a service user's flow through the system, via the provision of low and high intensity interventions. In establishing a stepped-care approach, consideration should be given not only to the degree of restrictiveness associated with a treatment, and its costs and effectiveness, but also to the likelihood of its uptake by a service user and the likely impact that an unsuccessful intervention will have on the probability of other interventions being taken up.

Despite the origins in the field of addiction (specifically the treatment of tobacco addiction, Sobell & Sobell, 2000), stepped-care systems have not been the subject of much formal evaluation in this area.

1.3 LOW-INTENSITY PSYCHOSOCIAL INTERVENTIONS

Low-intensity interventions are designed to increase access to evidence-based treatments on the understanding that many people will derive benefit without recourse to a more intensive programme. Such interventions usually involve less complex interventions; where contact with service users is generally briefer and can be delivered by paraprofessionals or peer supporters using non-traditional methods, such as self-help books, the telephone or the internet. Staff members who deliver these treatments support people in using evidence-based information to regain their self-management abilities,

where these have been adversely affected. The intervention involves giving information to people about their psychosocial problems and ways to overcome them. It also involves helping people through a supportive therapeutic alliance to make the best use of both this information and their own strengths. The provision of low-intensity psychosocial interventions gives people choice and flexibility and is delivered on the explicit premise that people are the best managers of their own recovery.

1.4 RECOVERY PRINCIPLES

Recovery is about building a meaningful and satisfying life, as defined by the persons themselves, whether or not there are ongoing or recurring symptoms or problems. Recovery represents a movement away from pathology, illness and symptoms to health, strengths and wellness. A sense of hope and possibility is central to recovery (Shepherd et al, 2008) and can be enhanced by each person seeing how they can have more active control over their lives ('agency') and by seeing how others have found a way forward. Self-management is encouraged and facilitated. The helping relationship between clinicians and clients moves away from being expert / patient to being 'coaches' or 'partners' on a journey of discovery. Recovery is closely associated with social inclusion and being able to take on meaningful and satisfying social roles within local communities, rather than in segregated services. Recovery is about discovering – or re-discovering – a sense of personal identity, separate from illness or disability.

Many of the ideas underpinning the recovery philosophy are based on self-help, empowerment and advocacy and provide a challenge to traditional notions of professional power and expertise which pervaded mental health services. These ideas had their roots in self-help groups such as Alcoholics Anonymous where the concept of being 'in recovery' remains a central principle and is defined as an amelioration of symptoms to a sufficient degree that they no longer interfere with daily functioning, allowing the person to resume personal, social and vocational activities (Davidson & McGlashan, 1997). Thus, recovery provides a conceptual framework, focused on self-management and a 'strengths' approach on what people can do, rather than what they cannot (Rapp & Goscha, 2006; Perkins, 2006).

1.5 SELF-HELP BOOKS

Self-help books are being increasingly used as a low intensity intervention. This is a positive development, reflecting UK government recommendations supporting the use of

self-help for the treatment of common mental health problems in primary care (NICE, 2009).

Self-help materials have often been referred to as ‘psychoeducation’ or ‘bibliotherapy’. Psychoeducation is a more general approach involving the provision of therapeutic information, which could include written materials, support and advice from professionals, and also group discussion and teaching sessions. Bibliotherapy is defined here as the unsupported use of written materials, and at the same time quality assured or specifically endorsed those self-help books and materials considered to be effective. This type of development is often referred to as a ‘book prescription scheme or service’ and was pioneered some years ago by Neil Frude with the involvement of public lending libraries in the Cardiff area. In addition to self-help books and leaflets, a range of cassette tapes, DVDs and computer programmes (CD-ROM or web-based) are now available.

There is a distinction between simply providing information to people and providing guided self-help. Guided self-help is a more structured treatment method with which the service user can help themselves with some support from another person; in addition, this approach requires the recipient to work with the contents of the self-help material to overcome their problems and achieve their goals (Lucock, 2007). Most current recommended self-help approaches in adult mental health services use a cognitive, behavioural or problem-solving approach. Guided self-help is a self-administered intervention designed initially to treat anxiety and depression, which makes use of a range of books or a self-help manual that is based on an evidence-based intervention (in the case of this framework, cognitive behavioural therapy (CBT)) and designed specifically for the purpose. A healthcare professional facilitates the use of this material by introducing, monitoring and reviewing the outcome of such interventions (NICE, 2007).

Main elements of guided self-help are: (i) engaging the person in guided self-help, (ii) identifying key problems and goals to work on, (iii) identifying appropriate self-help materials, (iv) supporting the person in their efforts to change, (v) review progress and the need for further help and (vi) use of assessment and outcome measures to help assessment and review of progress.

1.6 EVIDENCE-BASE FOR GUIDED SELF-HELP BOOKS

Guided self-help books have been shown to be an effective treatment in itself and helped to reduce time spent in subsequent therapy (Kenwright, 2005). In general mental health, there is considerable evidence that low-intensity interventions can reduce the level of both depression and anxiety. Various different aspects of self-help have been extensively evaluated and systematically reviewed for anxiety (Bower et al, 2001; Gellatly et al, 2007; Hirai & Clum, 2006) and depression (Anderson et al, 2005; Gellatly et al, 2007; Gregory et al, 2004) and has been endorsed as an intervention for mild to moderate anxiety and depression by a series of NICE recommendations (NICE, 2004; 2006; 2009). Self-help books on prescription (BoP) schemes (Frude, 2005) underwent a considerable expansion following UK DOH recommendations regarding the use of written self-help interventions for the treatment of depression and anxiety in primary care. Accordingly, it has become a major component of 'low-intensity' interventions for common mental health problems, which contribute to the IAPT Programme. For depression, the evidence supports the use of guided or facilitated self-help (including the use of computer delivered CBT). In anxiety, the evidence that facilitation is required is less strong but guided self-help is the model described for both anxiety and depression (Goldberg et al., 2004; McIntosh et al., 2004).

However, there has been debate about the effectiveness of psychoeducation or bibliotherapy and whether some forms of self-help materials are more effective than others (Richardson et al, 2008). The research evidence suggests that *guided* self-help where a practitioner is involved in supporting or coaching the person is far more effective than the provision of information alone (Gellatly et al, 2007; Hirai & Clum, 2006). Nevertheless, bibliotherapy and internet delivered CBT for social anxiety has been shown to be effective without direct therapist contact (Furmack et al, 2009). So it would appear that how self-help is provided may determine its efficacy. Moreover, it is likely that for some disorders such as PTSD, self-help or psychoeducational approaches may be ineffective (Scholes et al, 2007) or even potentially harmful (Wessely et al, 2008).

1.7. HOW TO CHOOSE EFFECTIVE SELF-HELP BOOKS

Within the context of IAPT services, the use of self-help books should not be a demanding task given the choice of the myriad of such materials that are now

commercially available. However, many IAPT services have reported not knowing which books are effective and should be employed within their local services.

A number of factors are central to selecting effective self-help books: these can be divided in 'specific' factors, 'common' factors, and 'personal narratives' (Bennett-Levy, 2010). *Specific* factor is, for example, the content of the book being evidence-based CBT. CBT has developed technical and specific 'empirically grounded' evidence-based therapeutic procedures that have been shown to be effective. It would seem that non-CBT based self-help books are not effective or even harmful (Gellatly et al, 2007). However, less than a quarter of the most easily accessed and popular 150 self-help books for depression are CBT based (Richardson et al, 2008). *Common* factors are the following: (i) the therapeutic alliance between the reader/service user and the book/facilitator, (ii) the structural aspects of the book (e.g. reading age, chapter length, and text size), (iii) whether the book generates hope in recovery, (iv) a collaborative framework (e.g. the use of exercises and person-centred goal setting). Recent work (Richardson & Richards, 2006) has questioned whether self-help books themselves can recreate some of these 'common factors' or whether these are the exclusive preserve of the human interaction between a person and a health worker. Indeed, Khan and colleagues (2007) found that the development of an effective therapeutic alliance determines whether people subsequently use self-help. This goes a long way to help us understand why guided self-help is effective while non-guided work has a much more doubtful evidence base. Finally, studies show that readers positively endorse books that include *personal narratives* they can identify with and stories that help the normalisation of experience (MacDonald et al, 2007). People report positively on books that include narratives that echo their own experience (MacDonald et al, 2007). While stories of recovery are important in books (Lovell & Richards, 2008), so are stories of struggle. Stories should give people hope but should not be so unrealistically positive that they appear false.

There are a large number of books available for self-help and unfortunately many do not meet these criteria. Choosing the 'right' book, therefore, presents a real challenge for practitioners helping service users undertake self-help. Therefore, skilled facilitation and choosing books wisely are the essential components of effective low intensity interventions. Self-help books should be evidence-based, engaging, factually accurate and reaching out to people through believable narratives. However, the effectiveness of

the intervention will often depend on the skill of the practitioner in identifying the right materials for individual people, providing a meaningful rationale for self-help books, and providing the appropriate amount of support. Central to this support is helping people move from a position of therapeutic passivity to one of active engagement with their own recovery.

1.8. THE USE OF SELF-HELP BOOKS IN ALCOHOL TREATMENT

Psychological interventions for people experiencing alcohol misuse or dependence have traditionally made use of the interaction between the service user and a therapist, worker, helper or counsellor. In addition, more recently, there has been some growth and expansion in the use of self-help based interventions that involve the use of DVDs, books, computer programmes or self-help manuals. The intervention is limited in nature, usually no more than three to five sessions, some of which may be delivered by telephone. Self-administered intervention is designed to modify drinking behaviour, and makes use of a range of books, web pages, CD-ROMs or a self-help manual that is based on an evidence-based intervention and designed specifically for the purpose. An example is Guided Self Change (GSC) (Sobell & Sobell, 1993). This treatment is manual-based and uses the principles of CBT and motivational enhancement therapy (MET). The client has an initial assessment followed by four treatment sessions and two follow-up telephone calls.

The effects of self-help books or 'bibliotherapy' in the treatment of alcohol were reported in few studies (Harris & Miller, 1990; Miller & Taylor, 1980; Miller et al., 1981; Sanchez-Craig et al, 1989, 1991). All investigators suggested that bibliotherapy is equally effective as more extensive, therapist-led treatment. All excluding Miller and Taylor (1980) reported slightly better (although not significantly better statistically) results for bibliotherapy. However, in all these studies, subjects who had been recruited had relatively low levels of alcohol-related problem severity. In three studies, a few (three or four) sessions of brief treatment of CBT were compared with more extensive treatment (Sanchez-Craig et al, 1989, 1991; Swenson et al, 1981). Again, no advantage was found in favor of more extensive treatment. In Project MATCH Research Group (1998), four sessions of MET showed results comparable with 12 sessions of 12-step facilitation therapy and 12 sessions of cognitive behavioral coping skills therapy.

In conclusion, guided self-help books have been shown to be an effective treatment in itself and can help to reduce time spent in subsequent therapy. Furthermore, these brief and person centered interventions can provide a highly effective initial treatment option when delivered in a stepped care model. Compared to the abundance of self-help books for those suffering general mental health problems, very little is known about what self-help books exist for alcohol treatment or their quality. The NICE full guidelines for alcohol-use disorders (2011) does mention the use of guided self-help as an intervention offered to families and carers. However, this guidance usually consists of a single session that focuses on information about ways to engage with self-help groups like A.A. (NICE, 2011). As yet, there are no specific NICE guidelines on self-help books as an intervention for alcohol problems.

2. STUDY AIMS

The general aim of this study was to provide alcohol service users with both information and access to useful self-help books on alcohol to promote their own sense of recovery.

Specific objectives:

1) To investigate the availability of self-help books for alcohol treatment and to identify 5 of these that could be assessed for their usefulness in the treatment of alcohol;

2) To explore what study reviewers (service users, carers and staff) say in general about the 5 selected self-help books for alcohol;

3) What specific features / content of the chosen books did study volunteers find useful and why;

4) To make recommendations on how the self-help books could be used within a treatment delivery programme.

3. METHODOLOGY

3.1 STUDY REVIEWERS

Reviewers were needed to provide comments and feedback on the chosen alcohol self help books. All reviewers were recruited from the staff members, service users and their carers at the Beresford Project (Greenwich Community Drug and Alcohol Project). The study authors (a Consultant Clinical Psychologist and Clinical Psychologist in Training) presented the aims of the study at the MDT business meeting and explained the purpose of the study to the members of staff (nurses, substance misuse workers, Specialist

Registrars, and Consultant Psychiatrist). The staff members interested in taking part in the study were asked to read one or more books and provide their comments and ratings of the book. Staff members were asked to return the book within a week. Staff members were also asked to approach service users individually within their therapy/key-working sessions, and carers within the carers' weekly support group, to ask them whether they wanted to participate in the study. Inclusion criteria for service users were the following:

- Regular alcohol consumption and/or alcohol dependency
- Willingness and ability to engage with the service
- An appropriate degree of lifestyle balance and reliable attendance

Each service user was given a £10 voucher for reading each book (money supplied by the Drug and Alcohol Action Team).

3.2 SELF HELP BOOK SELECTION AND DEVELOPMENT OF STUDY QUESTIONNAIRE

In order to explore the availability and usefulness of self-help alcohol books, the study needed to firstly identify a selection of self-help books and then provide a means of collecting the comments from the study reviewers. Both these processes are described in the sections below.

3.3 IDENTIFICATION OF SELF HELP BOOKS FOR ALCOHOL

A search of the literature was conducted using an on-line bookstore. Keywords included were: self-help, overcoming alcohol problems. The on-line bookstores self-reinforcing book popularity, independent of the book's relevance or quality, was taken into account. Pages were scrolled beyond the first page or two of results. A total of 30 books were found and reviewed. The 30 books are shown in a list in Appendix 1. In order to reduce this total list of books to the 5 needed for the study, the authors developed a screening and selection criteria. This screening and selection criteria was based on information highlighted in Section 1.7 of the Literature Review. The selection criteria were: (i) relevance, (ii) bestselling, (iii) number of pages, (iv) number of reviews/average customer review rate, and (v) cost. In addition to these, the literature review about how to choose effective self-help books was considered, by taking into account *specific factors* like the evidence-based therapeutic approach used in the book, and whether the book included *personal narratives*. Therefore, important consideration was given to the

authors' expertise (e.g. ex service users, mental health professionals) and book's main suggested theoretical approach (e.g. psychological therapy such as Cognitive Behavioural Therapy (CBT), Alcoholics Anonymous, Community Reinforcement and Family Training model (CRFT) etc).

The selected books were the following ones: (1) *'Don't Let the Bastards Grind You Down: 50 Things Every Alcoholic and Addict in Early Recovery Should Know'* (based on an ex service user's experience); (2) *'Overcoming Problem drinking: A self-help guide using CBT'*; (3) *'Living Sober'* (based on AA); and (4) *'Get your loved one sober: Alternatives to Nagging, Pleading, and Threatening'* (for carers, based on CRFT). Another book was added to this list: (5) *'What's your reason: a practical guide to recovery'* (based on CBT and recovery principles), a booklet offered to each service user who completed their detoxification programme in inpatient units within the South London and Maudsley Foundation Trust.

This process fulfilled the first objective of the study (See Section 2)

3.4 DEVELOPMENT OF STUDY QUESTIONNAIRE

To help staff members, service users and carers make ratings on the books, and to collect their feedback, the authors prepared a short questionnaire. This questionnaire took between 10-15 minutes to complete. As shown in Appendices 2 and 3, two questionnaires were developed, one for staff members, and one for service users and carers. An instruction sheet was developed for staff members, service users and carers**,** describing the study and explaining how to complete the questionnaires (see Appendix 4).

Careful consideration was made as to what questions to include in the study questionnaires. These decisions were guided primarily by information highlighted in the literature review of this study (see section 1.7). For example, the questionnaires included questions around *common factors*, like structural aspects of the books (chapter length, text size), a collaborative framework (exercises, person-centred goal setting), and whether the books generated hope in recovery. The questionnaires covered several areas for the evaluation of the books and included general questions to all reviewers about: (i) level of interest, (ii) length, (iii) level of difficulty, (iv) usefulness, (v) whether they provided good practical tips to tackle the alcohol problems, (vi) whether they

encouraged the reader to try out new things or any of the skills suggested, (vii) which tips/advice/skills the reader found most useful, (viii) which were the most useful chapters and why, (ix) what was not helpful, (x) whether they thought that the books should be offered to all service users during their treatment, (xi) whether they thought that it would be helpful to have them in the local library, (xii) whether they thought they were worth the money, (xiii) whether they would buy them, and (xiv) whether they had any additional comments. In addition, for the service users and their carers, the questionnaire included questions about whether they changed their view of drinking and how to deal with it and whether they would recommend the text to another service user. The staff questionnaire also asked reviewers to comment on how the book might help people in different stages of recovery and whether they thought it could be used alongside their normal key work tasks.

3.5 ETHICS

The study was approved by the Local Clinical Governance Department for Corporate Audits.

4. STUDY REVIEWERS' FEEDBACK OF SELF HELP BOOKS

4.1 REVIEWERS' GENERAL FEEDBACK ABOUT THE USE OF SELF-HELP BOOKS IN ALCOHOL

In total, 20 study questionnaires were completed (10 by staff members, 8 by service users, and 2 by carers). 100% of reviewers thought that the books were over-all useful and, when asked to rate how useful the books were, their average score was 8.1/10. 95% of reviewers thought that the books provided good practical tips to tackle the alcohol problems. 95% of reviewers thought that the books encouraged them to try out new things and, since reading the book, 70% service users tried out some of the new skills suggested. 100% reviewers thought that the books were interesting and, when asked to rate how interesting the books were, their average score was 8.4/10. 55% of reviewers rated the books to be 'too long' and 45% 'just about right'; the reviewers generally thought that the books were easy to read (the average score being 7.9/10). 60% of service users found that the books changed their view of drinking and how to deal with it. 90% of staff members would use the books alongside their own key work. 85% of reviewers would buy and/or recommend buying the books.

There was much overlap with many of the common factors identified in the literature review on self-help books for general mental health problems. Both the service users/carers and the staff members identified as the most crucial aspects across all of the books the following: (i) the structural aspects of the book (e.g. chapter length, and text size), (ii) whether the book generated hope in recovery, and (iii) a collaborative framework (e.g. the use of exercises and person-centred goal setting).

The personal narratives were also considered as important, particularly for the service users/carers. The reviewers positively endorsed books they could identify with and stories that helped normalise their experience, by giving hope and at the same time providing a realistic balance between recovery and struggle.

Interestingly, whether the content of the book was evidence-based or not was not considered as an important factor by service users, carers nor staff members. In addition, the different kind of approach used (CBT, CRFT, or AA) was not deemed to be essential.

This process fulfilled the second objective of the study (See Section 2)

4.2 SPECIFIC FEATURES OF BOOKS THAT REVIEWERS FOUND USEFUL AND WHY

a) What did service users find helpful?

A summary of the study found that few key themes emerged from the service users' perspective about how the books were helpful:

- Providing strategies they could use to manage their lives: the importance of structuring and managing the day, empowerment, physical health and wellbeing, and spirituality
- Highlighting the importance of social network and support in the recovery process
- Helping them become aware of low mood, anxiety and anger as precipitating and maintaining factors for the alcohol problem
- Normalising the service users' difficulties by externalising the problem, and instilling hope
- Being flexible for different people at different stages of their recovery

- Describing the personal experience (struggles and successes) of the authors, in a realistic and hopeful way, by providing a better understanding of the difficulties and coping strategies in a practical and open way

Table 1: Subjective experiences of service users using self-help books.

'It has given me ideas about ways to occupy my time because it is not stopping that's the problem, it's filling your time after stopping, and it is not a bad thing to accept the extent of your problem'; 'Now that I'm abstaining from alcohol I can go ahead and do some goal-planning for my life'
'I know how to deal with drinking by talking to AA and a friend – I know how alcohol is not my friend'
'It has shown me that it is not a good thing to drink in order to cope with problems, it only makes things worse, in terms of lowering mood and increasing anxiety'
'Very useful book for someone in recovery because the feelings you have mean you are not just mad'; 'It's a good all round book which covers all different problems for different people, especially someone who has been in the same situation as me'; 'gives you hope that you are not the only one with the same thoughts'
'I would recommend this book because it gives an insight of what people can do and explain how this horrible liquid can affect different people in different ways'
'What I found was interesting is how alcohol can affect people in different ways'; 'I enjoyed this book very much. Most of the chapters applied to me so I can look at my issues from a different angle now that I'm sober'
'This book is by someone who is a recovering alcoholic and knows what she is talking about […] what it might be like and how to cope when you are first sober'

b) What did carers find helpful?

Carers indicated the following as the most useful characteristics of the books:

- Giving tips about how important is for the carers to look after themselves to look after their loved ones better
- Instilling hope, as a realistic balance between struggle and recovery
- Giving responsibility back to the service user
- Providing understanding on how the problems developed and increasing awareness on what kept these going

Table 2: Subjective experiences of carers using self-help books.

'Looking after yourself keeping strong physically and mentally if at all possible'
'Instilling hope, positive, empathic'; 'Good metaphor of road map/journey + realistic expectations'; 'Examples of other people's experiences/successes -> hope'; Examples of people the authors have worked with'
'This book makes you realise the pattern that the drinker follows and gives you a bit of a confidence boost to think that none of this is your fault'
'Personally I would like to have read this book at the beginning of his treatment. I feel that I would have been able to help him sooner or that I would have understood a lot more of what we were both going through, a lot sooner'

c) What did staff members look out for when reviewing self-help books?

Staff would notice more than service users the specific approach described in the book (CRFT, or AA) not by focusing on the evidence-base per se, but as a way to highlight the potential benefits of psychoeducation and information provision, to offer more choice to their clients, as active agents of their own recovery, to boost their confidence and increase self-efficacy. In addition, staff members would look for how the book would be appropriate for service users' different cognitive abilities and level of use (e.g. chaotic or regular) in a stepped-care fashion approach, and particularly for their motivation, readiness to change and recovery stages. Therefore, key characteristics emerged from the staff members' perspective about how the books were helpful were as following:

- Being drawn on personal narratives, instilling hope, being based on recovery principles
- Being accessible and easy to introduce to service users' chaotic life style, manageable and relevant
- Having worksheets that could be printed out or photocopied for key working sessions
- Enhancing the carers' involvement
- Offering psychoeducation and providing information on different treatment approaches available
- Being flexible to the service users' different needs and recovery stages

Table 3: Subjective experiences of staff members reviewing self-help books.

'Packed full of sensible, practical and honest advice. The text is always hopeful and will help others believe recovery is achievable'; 'The author's experience is what most of our clients will go through'; 'The chapters cover lots of relevant parts of recovery'; 'It is written by people who used to have alcohol problems -> personal experience of authors'; 'Normalisation and externalisation of the problem -> giving responsibility back to the reader/service user'
'A very clearly written book. It is so simple to read and it is a book you can dip in and out as well as reading it cover to cover'; 'Easy reading – service users can carry the book with them'; Short chapters – service users can manage to read it on a daily basis'; 'I liked the short length of the book and chapters. Easy to read, jargon free'; 'Good cover – people would not understand the content of the book -> service users would be comfortable in carrying the book around with them'; 'I think the title of the book is very good and will catch people eye, if I saw it in a library or book shop I would pick it up'; 'It's a very good book – easily read, sense of humour and it is relevant to our clients'
'The chapters are very short and easily could be discussed in key working sessions'; 'I think this book would be a useful tool for a key worker who could adapt it and print out the exercises and summaries'; 'Gives good grounds for key working sessions and topics to be explored in more detail'; 'Very practical guide – could be used with key work sessions to reflect on progress, barriers to recovery and dealing with co-morbid problems (anxiety, anger, depression)'; 'Useful tips would need a lot of work to do this with family and carers', 'It would be helpful for sessions where the carer is involved'
'The most useful parts of the book are the exercises, the highlighted sections, and the bullet pointed summaries. Those are the practical things clients can do'; '[…] space for service users' comments, diagrams/pictorial content/visualisation of certain examples/concepts'; 'At times the spaces left for clients' comments did not seem large enough for ideas/comments that clients may have – perhaps tables could be enlarged and photocopied for clients'; Exercises (e.g. Drinking diary, Problems – targets analysis, Increasing pleasurable activities, Relaxation tips, Control drinking skills, Challenging positive thoughts about drinking, Tackling craving, Improving sleep)'
'The main focus of this book is AA. The most useful chapters are therefore ones which describe AA and how to use it in the initial phase'; 'Some useful chapters to give as handouts for those wanting to know about AA & how to use it'; 'based on CRAFT'
'I like this book, I think it is useful for clients ready to make changes and ones who are still contemplating changes to guide through think process'; 'It would be useful in detox/rehab/aftercare setting'; 'Useful for some service users depending on stage and level of use. Also individual cognition and intellectual capabilities'

The tips, advice, skills and chapters that were indicated as most useful are reported in the description and feedback section for each book in Appendix 5.

This process fulfilled the third objective of the study (See Section 2).

4.3 RECOMMENDATIONS ON HOW BOOKS CAN BE USED WITHIN A TREATMENT DELIVERY PROGRAMME

80% reviewers thought that the books should be offered to all service users during their treatment. 90% reviewers thought it would be helpful to have these books in the local library. 70% service users would recommend the books to a friend.

The reviewers generally thought that the books were easy to read (the average score being 7.9/10), however the CBT based book average score was 5.5 and this is the reason why we explicitly asked our reviewers to give specific information on helpful chapters, worksheets etc for each book.

Regarding trying out some of the new skills suggested, as stated above, 70% service users did so, however carers ad staff members did not reply as they did not consider this point as applicable to them.

This process fulfilled the last objective of the study (See Section 2).

5. SERVICE AND BOROUGH RELATED OUTCOME BASED ON FEEDBACK OF SELF HELP BOOKS

The feedback received from the study reviewers was used to change treatment delivery at the Greenwich Community Drug and Alcohol Service and IT also had wider implications for access to treatment for alcohol users in the Greenwich Borough.

5.1 SERVICE RELATED CHANGES

All the books became available to all services uses via the ‘Peer Support Resource Centre’ run by ex-service users.

The reviewers’ feedback was collated and made available to all service users and their carers via an information sheet to offer them choice and help them make their decisions as to which text (and chapters) may suit their particular needs.

Specific chapters of the books, as recommended by the reviewers, have been routinely incorporated into treatment delivery. For example, specific chapters from ‘Get your loved one sober’ are now given to carers supporting service users during community detoxification.

Key-workers were trained in the use of self-help books, by feeding back to them the recommendation of chapters from their reviews, and supporting them in how to use guided self-help books in key-working sessions.

The books, as well as other self help material, are being used on a regular basis to help train the staff team in recovery focused interventions.

5.2 BOROUGH RELATED CHANGES

The results of the study have been disseminated across other Borough Addiction services who are now routinely recommending these books to their service users.

Local libraries in the Greenwich area have given their guarantee to stock the best books selected through the study, so that service users will have permanent access to them. Like other self help books, it is hoped these 5 books will become available on the prescription scheme (Frude, 2005).

Work is underway in the Borough for these self-help books to be recommended by other health services, such as GPs and IAPT etc.

It will now become a service standard that all service users are informed about the value of self help books and provided with information as to the useful books as highlighted by the study.

6. WIDER IMPLICATIONS FOR STUDY FINDINGS AND OUTCOME

6.1 STIGMATISATION AND EMPOWERMENT

These findings show that with self-help books service users do not feel as ashamed and stigmatised as they would be if actively seeking help from professionals by having to admit they have failed to cope. With self-help books they focus on being able to cope, rather than their ‘symptoms’, and prioritise regaining everyday functioning and social roles in their recovery. In addition, while service users often believe that getting treatment means further loss of control, when describing their views of self-help books, they often viewed their role as being in initiating therapy rather than receipt of treatment.

Furthermore, low intensity practitioners may be faced with service users who believe that the worker has the knowledge and power to 'cure' them. They may believe that they must cede control to the worker as part of the process of engaging in treatment. As such they may find the emphasis on self-help more realistic, less frustrating and somewhat different from their initial expectations of therapy.

In addition, these findings identify the need to respond to carers affected by their loved ones' alcohol misuse in their own right. Family members in these circumstances often suffer significant levels of physical and psychological stress-related symptoms. Guided self-help books specifically for family members provide the opportunity to explore their situation, provide specific targeted information and explore a family member's interactions with the service user (Copello et al, 2005; Copello et al, 2009).

6.2 *GUIDED* SELF HELP

Given the fact that books will always struggle to fully replicate the more sophisticated common therapeutic techniques necessary to develop and maintain therapeutic relationships, these techniques need to be used specifically by practitioners themselves as part of the supportive relationship in guided self-help. The best way to do this is through the therapeutic relationship. Indeed, Khan and colleagues (2007) found that the development of an effective therapeutic alliance determines whether people subsequently use self-help. This goes a long way to help us understand why guided self-help is effective, while non-guided work has a much more doubtful evidence base.

There is clear evidence in both anxiety and depression that self-help books alone are clinically ineffective (Gellatly et al, 2007; Hirai & Clum, 2006). The addition of guidance renders self-help effective, however, guidance alone will also be insufficient if the self-help book chosen is poorly written, contains inaccurate information or, worse, suggests harmful or non-evidence based procedures. The combination of information and support is central to effective delivery of low intensity interventions. Therefore service users need:

- information on why this approach is likely to work (the rationale)
- information about the specific techniques themselves
- provision of recording sheets and diaries, together with interpersonal support while they put their exercises into action

The presence of a guide, coach, or facilitator is positively associated with clinically effective change for service users (Gellatly et al, 2007). Low intensity practitioners should sensitively introduce self-help books and manage service users' expectations so that they become partners in care. Staff members should ensure that any advice given within a self-help book would be consistent with advice they would provide. It is essential, therefore, that staff members choosing specific self-help books become fully familiar with their content before recommending use. Low intensity practitioners should, therefore, be advised to become knowledgeable about a small number of self-help books, which they have detailed knowledge about and feel comfortable with the content.

6.3 HOW TO CHOOSE THE RIGHT BOOK

The effectiveness of the intervention will often depend on the skill of the practitioner in identifying the right books for individual people. The selection and use of self-help books that are readable, engaging, factually accurate and reach out to people through believable narratives is a skilled activity requiring the right books to be available at the right time with the right amount of guidance. Staff members need to be supported to develop the skills to discriminate between books and use them, appropriately guided by four principles: 1) To be informed by the evidence base; 2) To provide a meaningful rationale for self-help books; 3) To provide the appropriate amount of support; and 4) To be supported within a system that conducts regular audit of books and other self-help materials.

Below we discuss a number of factors that this study's findings indicated as central to selecting effective self-help books:

- Structural aspects of the books can make it more likely that they will be used. Staff members can apply simple objective criteria, such as reading age, chapter length, and text size, and other factors such as whether the sentence structure is long and complex, and whether the books are well-designed.

- In addition, workers should use books that develop a collaborative framework through the use of exercises and person-centred goal setting, by providing a structure that encourages trying out what is learned and helping the person to review the outcomes. Importantly, making these judgements requires staff members to put themselves in the

position of a service user, perhaps one who is frightened or lacking in motivation and energy, and imagine whether they would feel engaged by the way a book 'talks' to them.

- Finally, staff members should choose books that include realistic narratives to normalise the service users' experiences, connect them to real life experiences to help them make connections between what they are reading and their own life (MacDonald et al, 2007). These stories should use personal metaphors for emotional distress, be culturally appropriate and believable.

6.4 DISSEMINATION OF FINDINGS

As mentioned in Section 5.1, the dissemination of findings has started locally at the Beresford Project. Firstly, key workers have been informed about the result of this study and have been encouraged to promote their use with service users. Since this study, there have been examples of where service users have bought their own copies and in other examples, service users and carers have been given specific chapters to read. Secondly, the Beresford Project is developing another treatment protocol / manual to support service users and carers in their preparation for detoxification and the self help books (and specific chapters as recommended by the study) are being incorporated into these sessions. Lastly, the books are being promoted through the newly developed Service User Lead Resource Centre at the Beresford.

As mentioned in Section 5.2, the results of the study have been disseminated within the Greenwich Borough by making sure that: (i) all the books are promoted by other addiction services in the Borough (ii) Greenwich libraries have given assurance that they will stock the books recommended by this study (iii) the self-help books will be recommended by other health services in the Borough, such as GPs and IAPT.

Finally, the results of the study have been disseminated at the South London and Maudsley Trust Psychology Conferences in November 2011 and the project has been nominated in the Addictions CAG Governance Quality & Excellence Awards 2012 for service user involvement.

6.5. THE STEPPED-CARE FRAMEWORK AS A WAY TO DELIVER GUIDED SELF-HELP INTERVENTIONS

These findings support the stepped-care framework as a way to deliver guided self-help interventions of recovery and after-care reintegration. In most cases, it is important to deliver high- and low-intensity interventions in the context of an agreed care plan, co-ordinated by a keyworker. Indeed keyworkers will, in many cases, already be delivering the majority of the low-intensity interventions provided – as their work already utilises components from motivational interviewing along with components drawn from other interventions such as relapse prevention. The categorisation here into a framework that is based on intensity is intended to support further the integration of these evidence-based interventions into routine care planned treatment. The categorisation by intensity may also be particularly helpful in facilitating the development of effective treatments of common mental health problems in alcohol and drug services (through the use of guided self-help and other low-intensity CBT interventions), as there may be currently only limited experience in many. In practice, these different interventions may be executed in parallel as part of a comprehensive treatment plan agreed with the service user.

The NICE produced guidelines on interventions for alcohol misuse, integrated within the 'stepped care' framework. The key low-intensity, evidence-based psychosocial interventions for alcohol misuse identified are motivational interviewing and contingency management, which both focus primarily on the presenting alcohol problem with the aim of reducing alcohol misuse or reducing alcohol-related harm. In the field of alcohol misuse there are well-developed brief interventions which are suitable for use in a stepped-care system (NICE, 2010) such as brief motivational interventions, but other low-intensity interventions which are less dependent on the availability of professional staff and focus on client-initiated approaches to treatment are also available and include self-help materials such as books and computer programmes (Bennet-Levey *et al.*, 2010). In addition, many alcohol treatment services already operate forms of stepped care and they are implicit in current national policy guidance (MoCAM; DOH, 2006) but as yet there has been little formal evaluation or systematic review of the area. The NICE guidelines (2011) review team conducted a new systematic search for RCTs and systematic reviews that assessed the efficacy of stepped-care approaches in alcohol-related disorders. Three trials relating to clinical evidence that potentially met the eligibility criteria set were found, providing data on

496 participants (Bischof, 2008; Breslin, 2009; Drummond, 2009). In summary, three studies assessing stepped-care methods found that there may be a small effect in favour of stepped care, for hazardous drinkers. There were no significant differences found on alcohol outcomes for more harmful and severely alcohol dependent people. The relation between number of sessions and effects of treatment for alcohol-related problems is not straightforward. A systematic search of the literature for randomized controlled studies yielded six that reported comparisons between a single session of treatment and more extensive treatment (Bennie, 1998; Chapman & Huygens, 1988; Chick et al, 1988; Edwards et al, 1977; Sannibale, 1988; Zweben et al, 1988). In only one of these studies (Chick et al, 1988) did the findings reveal any statistically significant advantage for more extensive treatment.

7. LIMITATIONS OF THE STUDY

There were a few methodological limitations to this study.

The study was successful in highlighting a small number of self help books that could benefit service users accessing support for problems related to alcohol use. The study was limited to reviewing a small number of books because of both cost restraints in buying the original texts and limited resources available to collect and analyse the data. Future studies in this area may like to focus on a greater number and range of books, also including books focused on drug misuse.

In addition, the study suffers from a fairly small sample size meaning that the findings and the conclusions drawn may not necessarily be representative of the general feeling among all service users, carers, and staff members. The service user and carer reviewers were also selected for the study since they were all engaged with the services and had an appropriate degree of lifestyle balance and reliable attendance. Future studies may choose to counter such limitations by collecting a larger number of reviews of the books and across service users in different stages of their treatment journey and from a wider socioeconomic background.

Finally, in line with good practice guidance on service user involvement in delivery of clinical services, this study asked both service users and carers to provide feedback about the self help books and did promote treatment choice by disseminating the recommendations for accessing these self help books through other addiction services,

local libraries and IAPT services. Service user and carer participation could have been increased if they had been more explicitly involved during the development of the study questionnaire. A more systematic emphasis on sharing this task would represent the important goal of involving service users at different levels of the evaluation process and perhaps made the questionnaire more ecologically valid and meaningful to their needs.

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http://www.ntw.nhs.uk/pic/leaflet.php?s=selfhelp

APPENDICES

APPENDIX 1: BOOKS LIST

TITLE	AUTHOR	PRICE (£)	PAGES	REVIEWS	AVERAGE CUSTOMER REVIEW (0-5)	SORTED BY
Recovery from Addiction: A Practical Guide to Treatment, Self-help and Quitting on Your Own	William Cloud and Robert Granfield	12.99	248	no		relevance
Alcohol: How to Give it Up and be Glad You Did	Philip Tate	6.97	208	2	4	relevance
Beat the Booze: A Comprehensive Guide to Combating Drink Problems in All Walks of Life	Edmund Tirbutt	6.49	289	33	4.5	relevance + bestselling
Addiction and Recovery for Dummies	David Lewis, Brian Shaw, Paul Ritvo, and Jane Irvine D.Phil	7.09	312	1	1	relevance
Empowering Your Sober Self: The LifeRing Approach to Addiction Recovery	Martin Nicolaus	12.59	272	1	5	relevance
Don't Let the Bastards Grind You Down: 50 Things Every Alcoholic and Addict in Early Recovery Should Know	Georgia W.	7.49	168	7	4.5	relevance + bestselling
The Effective Way to Stop Drinking	Beechy Colclough	5.99	256	5	2.5	relevance
Mindful Recovery: A Spiritual Path to Healing from	Thomas Bien and Beverly Bien	7.14	256	1	5	relevance

Addiction						
Overcoming Addiction: Positive Steps for Breaking Free of Addiction and Building Self-esteem	Corinne Sweet	2.99	308	1	5	relevance
Controlling Your Drinking: Tools to Make Moderation Work for You	William Miller and Ricardo Munoz	11.17	226	no		relevance
I've Lost My Way	Levi Lorang	14	328	no		relevance
Addictions: A Banquet in the Grave: Finding Hope in the Power of the Gospel (Resources for Changing Lives)	Edward T Welch	10.95	298	1	5	relevance
7 Tools to Beat Addiction	Stanton Peele	5.99	288	3	4.5	relevance
The Miracle Method: A Radically New Approach to Problem Drinking	Insoo Kim Berg	8.95	192	no		relevance
Kicking Addictive Habits Once and for All: A Relapse Prevention Guide	Dennis Daley	15.29	224	no		relevance
The Easy way to Control Alcohol	Allen Carr	4.68	256	3	4.5	bestselling
Allen Carr's Easy Way to Control Alcohol	Allen Carr	5.99	188	93	4.5	bestselling
Changing for Good	James Prochaska and Carlo Di Clemente	5.79	304	8	5	bestselling
Freedom from Addiction: The Secret Behind Successful Addiction	Joe Griffin and Ivan Tyrrell	6.24	248	10	4.5	bestselling

Busting (Human Givens Approach)						
Overcoming Problem Drinking A self-help guide using CBT	Marcantonio Spada	7.04	256	4	4	bestselling
Living Sober	AA Services	6	92	5	4.5	bestselling
The Easy Way to Stop Drinking: A Revolutionary New Approach to Escaping from the Alcohol Trap	Allen Carr	7.89	272	10	4	bestselling
Cleaning Up: How I Gave Up Drinking and Lived	Tania Glyde	4.78	256	17	4	bestselling
The Addiction Workbook: A Step-by-step Guide to Quitting Alcohol and Drugs	Patrick Fanning and John O'Neil	15.29	160	no		other
The Demon Drink	Jancis Robinson	21.95	192	no		other
Let's Drink to Your Health! A self-help guide to sensible drinking.	Robertson and Heather Nick	19.99	160	no		other
The Healing Journey Through Addiction: Your Journal for Recovery and Self-Renewal	Phil Rich and Stuart Copans	12.59	272	no		other
Addictive Thinking: Understanding Self-deception – How the Lies we Tell Ourselves and Others Perpetuate Our Addictions	Abraham Twerski	7.10	152	4	5	other
No Big Deal: A Guide to Recovery from	Robert Lefever	7.99	160	19	5	other

Addictions						
Get your loved one sober: Alternatives to Nagging, Pleading, and Threatening	Robert Meyers and Brenda Wolfe	6.95	240	no		other

APPENDIX 2: SELF-HELP BOOK QUESTIONNAIRE: STAFF VERSION

Book title: _____

1. How interesting was this book? (Please circle your selected option)

Not interesting at all 0 1 2 3 4 5 6 7 8 9 10 V ery interesting

2. Was this book; too long? Too short? Or just about right? Please circle your selected option.

3. How easy was this book to read? (Please circle your selected option)

Not easy to read 0 1 2 3 4 5 6 7 8 9 10 V ery easy to read

4. Did the book provide good practical tips to tackle the alcohol problems? Yes / No. (Please circle your selected option)

5. Does the book encourage the reader to try out new things? Yes / No. (Please circle your selected option)

6. Since reading the book have you tried out any of the new skills suggested? Yes / No. (Please circle your selected option)

7. Which tips/advice/skills do you think the reader will find most useful? Please indicate where they appear in the book (page number/chapters)

_____
_____ _____
_____
_____
_____ _____

8. Overall, how useful do you think this book would be to those with problems with alcohol? (Please circle your selected option)

Not useful at all 0 1 2 3 4 5 6 7 8 9 10 V ery useful

9. What is/are the most useful chapters of this book and why?

_____
_____
_____ _____
_____
_____

10. And what was not so helpful?

_____
_____
_____ _____
_____
_____ _____

11. Do you think that we should offer this book to all service users during their treatment? Yes / No. (Please circle your selected option)

12. Would you use this book alongside your own key work? Yes / No. Please circle your selected option and give a brief explanation below why you think this.

_____ _____
_____
_____
_____ _____
_____

13. Do you think it would be helpful to have this book in the local library? Yes / No. (Please circle your selected option)

14. You'll find the price of the book inside the front cover. Do you think that this book was worth the money? Yes / No. (Please circle your selected option)

15. Would you recommend service users to buy this book? Yes / No. (Please circle your selected option)

16. Additional comments: Please write any other comments you wish to make about this book below.

_____
_____ _____
_____
_____
_____ _____

Thank you for your time in completing this questionnaire

APPENDIX 3: SELF-HELP BOOK QUESTIONNAIRE: SERVICE USER / CARER VERSION

Book title:
_____

1. How interesting was this book? (Please circle your selected option)

Not interesting at all 0 1 2 3 4 5 6 7 8 9 10 V ery interesting

2. Was this book; too long? Too short? Or just about right? Please circle your selected option.

3. How easy was this book to read? (Please circle your selected option)

Not easy to read 0 1 2 3 4 5 6 7 8 9 10 V ery easy to read

4. Did the book provide good practical tips to tackle the alcohol problems? Yes / No. (Please circle your selected option)

5. Did this book encourage you to try out new things? Yes / No. (Please circle your selected option)

6. Since reading the book have you tried out any of the new skills suggested? Yes / No. (Please circle your selected option)

7. Which tips /advice/skills did you find most useful? Please indicate where they appear in the book (page number/chapters)
_____
_____
_____
_____
_____

8. Has this book changed your view of drinking and how to deal with it? Yes / No. (Please circle your selected option). If yes, in what way? Please explain below.
_____
_____
_____
_____
_____

9. Overall, how useful was this book? (Please circle your selected option)

Not useful at all 0 1 2 3 4 5 6 7 8 9 10 V ery useful

10. What is/are the most useful chapters of this book and why?
_____
_____
_____

_____
_____ _____

11. And what was not so helpful?

_____
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12. Do you think that we should offer this book to all service users during their treatment? Yes / No. (Please circle your selected option)

13. Would you recommend it to a friend? Yes / No. Please circle your selected option and give a brief explanation below.

_____ _____
_____
_____
_____ _____
_____ _____

14. Do you think it would be helpful to have this book in the local library? Yes / No. (Please circle your selected option)

15. You'll find the price of the book inside the front cover. Do you think that this book was worth the money? Yes / No. (Please circle your selected option)

16. Would you buy this book? Yes / No. (Please circle your selected option)

17. Additional comments: Please write any other comments you wish to make about this book below.

_____
_____
_____ _____
_____
_____ _____

Thank you for your time in completing this questionnaire

APPENDIX 4: QUESTIONNAIRE INSTRUCTIONS SHEET

South London and Maudsley NHS
NHS Foundation Trust

Instructions sheet

Dear service user / carer / staff member

We would appreciate if you could please spend few minutes reading this leaflet about a new service the Beresford Project would like to offer you.

Research has shown that self-help books can provide useful tips and advice on how to change behaviour. There are many self-help guides available that give advice on how to tackle problems associated with alcohol use. However, there is little feedback about which of these guides is really useful and why.

Aim of project:
The purpose of this project is to get a number of service users and staff to read a selection of these books and to give us ratings on how useful they were. Our aim is to use this feedback to make future recommendations to service users about what books were helpful and why. Some of the best books from the review will also be placed in local libraries.

What do you have to do?
If you decide to take part in this study you will be asked to read one or more books and provide your comments and ratings of the book. There are five books to choose from. The books we suggest have been selected by their relevance to alcohol problems, their length, reviews on Amazon and whether they are bestsellers.

To help you make ratings on the book we have prepared a questionnaire (on the next page). The questionnaire should take between 10-15 minutes to complete.

We only have one copy of each book so please don't write in the books and can you return the book within a week.

How will your involvement help others?
Your comments will be placed on an information sheet as reviews for future readers. The best books from the review will be recommended to other service users and some of the books will be made available in the local library!

All service users will receive £10 from the DAAT for their support with this project.

Many thanks for your time. This will be very helpful

APPENDIX 5: FEEDBACK ON EACH BOOK

'Don't let the bastards grind you down: the fifty things every alcoholic and addict should know'

This book is full of suggestions that can work for anyone who is new to recovery or trying to overcome their drinking problem. The author has drawn on her own experiences and that of others in early recovery to determine the 'fifty things every alcoholic and addict should know,' including: 1) the first thirty days – what to expect and how to get through it, 2) things to avoid – protecting your recovery and coping with stress, 3) relapse – warning signs and moving forward if it happens, 4) family – how to include them and re-build relationship, 5) dating in recovery - the not so good, the bad and the ugly, 6) dry drunk – how not to be one, and 7) twelve step programs – how they work and what you should know. "If you have a substance abuse problem and want to quit or are new to sobriety and don't know what to expect, read this book. It's different, down to earth and a very easy read. 'Don't Let the Bastards Grind You Down is not your typical recovery book". – Tom Chenault, Radio Talk Show Host and Recovering Alcoholic.

How interesting was the book?	2 s.u. av. score = 9 2 staff av. score = 8.5 Tot av. score= 8.75
Length of the book	too long 1 too short just about right: 3
How easy was the book to read?	2 s.u. av. score = 9.5 2 staff av. score = 9.5 Tot av. score= 9.5
Did the book provide good practical tips to tackle the alcohol problems?	Yes 4
Did this book encourage you to try out new things?	Yes 4
Since reading the book have you tried out any of the new skills suggested?	Yes 1 (staff) No 1 (client)
Which tips /advice/skills did you find most useful?	'there was no specific tips, advice, skills that stood out, I would say the whole book was good in general (page 135 making amends, it was good advice about trying to sort things with people you have hurt)'; 50 progress not perfection 45 not so great expectation 22 depression 20 I want it and I want it now 9 fuck your feeling 6 some thing you might want to avoid; Not substituting alcohol with shopping or food because it may turn into an addiction like alcohol (p.37 substituting + fixing);

	Sensible tips to coping strategies (e.g. dealing with celebrations, chapter 13; isolation ch 12; triggers, ch 7; repairing relationships with children, ch 19; all the chapters in preparing someone for AA, ch 26 -> 43; dealing with patience, ch 20)
Has this book changed your view of drinking and how to deal with it? (client)	Yes 2 'It has given me ideas about ways to occupy my time because it is not stopping that's the problem, it's filling your time after stopping, and it is not a bad thing to accept the extent of your problem'; 'I know how to deal with drinking by talking to AA and a friend – I know how alcohol is not my friend'
Overall, how useful was this book?	2 s.u. av. score= 8.5 2 staff av. score = 9 Tot av. score = 8.75
What is/are the most useful chapters of this book and why?	'I would say the first because I am still on the run up to detox (again) it gives you a fresh insight which you forget when you start drinking again and similarities in thinking which gives you hope that you are not the only one with the same thoughts'; 'The chapters are very short and cover different issues – I like all the chapters'; 'Firsts in the first year p.43 – what it might be like and how to cope when you are first sober. This book is by someone who is a recovering alcoholic and knows what she is talking about'; Covered in question 7. The main focus of this book is AA. The most useful chapters are therefore ones which describe AA and how to use it in the initial phase.
And what was not so helpful?	'None was not helpful because it is good to look at all different aspects. And how other people cope'. 'Swearing in the book and the title'; 'the chapter on Higher Power p.121 (boring)'; Some useful chapters to give as handouts (a service user perspective) – for those wanting to know about AA & how to use it
Do you think that we should offer this book to all service users during their treatment?	Yes 4
Would you recommend it to a friend? (client)	Yes 1 No 1 Simply because none of my friends have my sort of problem or not that they would admit

	'mainly for the chapter about being sober for the first year p.43 + good advice about 'staying stopped' p.84 (old hobbies, acupuncture etc).
Would you use this book alongside your own key work? (staff)	Yes 2 'The author's experience is what most of our clients will go through – the chapters cover lots of relevant parts of recovery; The chapters are very short and easily could be discussed in key working sessions'
Do you think it would be helpful to have this book in the local library?	Yes 4
Do you think that this book was worth the money?	Yes 3
Would you buy/recommend to buy this book?	Yes 4
Additional comments	'It's a very good book – easily read, sense of humour and it is relevant to our clients' 'I think the title of the book is very good and will catch people eye, if I saw it in a library or book shop I would pick it up'; I liked the short length of the book and chapters. Easy to read, jargon free. Packed full of sensible, practical and honest advice. The text is always 'hopeful' and will help others believe recovery is achievable.

Living sober

The Living Sober book written by Alcoholic Anonymous World Services Inc is a booklet which reviews what an alcoholic/drug addict needs to do to stay sober from Day 1 and utilising the 12 steps of recovery throughout the journey of recovery. It gives a brief introduction as to how alcoholics must understand that this is a disease that needs to be treated like any other disease. It also sets out, explaining to the alcoholic that the methods that need to be used to be able to live sober without drinking. It touches on subjects like "keep an open mind" "use your own common sense" "staying away from that first drink" and "using the 24-hour plan." The Alcoholics Anonymous start with these topics in order to help the alcoholic to begin the transition to living sober. This living sober book also tells the addict in no uncertain times that it is a lifelong, progressive, fatal disease if not treated with the 12 steps. Alcoholics Anonymous continues by providing easy slogans for the addict to remember. For example "live and let live" is suggested in order to assist the alcoholic recognize how they cannot control other people and that they need to hear what their past drinking caused to relatives and friends. The book sets out how the initial important things are getting active, especially in and around A.A. But even activity not related to A.A. is helpful. These subjects that are covered in brief explain how AA works and how important it is to get a sponsor, attend meetings and continually recite and rely on the Serenity prayer. The book also gives advice and hints that have been used by other alcoholics/addicts to assist recovery by changing old routines, eating/drinking something sweet, and making use of telephone therapy and unconditionally surrendering the alcoholic's will with the guidance of a sponsor. This book also provides insights into what situations to look out for by an alcoholic to avoid a relapse. It details how staying away from people places and things that the addict frequented during usage and to avoid anger and resentment and to fend off loneliness can aid the recovery process. The book also advises the alcoholic to be good to oneself, to get plenty of rest, not to reach a level too quickly in the program but to "easy does it" in terms of understanding the 12 steps of recovery. Also to be grateful that the alcoholic can have sobriety and to be humble. In addition to the standard alcoholic's perception, the 12-step program is also applied to gambling, sex and other addictive behaviour. Therefore, this book, from an alcoholic's perspective, is a must read and is the beginning of recovery for the addictive personality/disease for the alcoholic/addict.

How interesting was the book?	2 s.u. av. score = 9 2 staff av. score = 7.5 Tot av. score = 8.25
Length of the book	too long 3 too short just about right 1 'Short chapters – service users can manage to read it on a daily basis'
How easy was the book to read?	2 s.u. av. score = 5.5 2 staff av. score = 5.5 Tot av. score = 5.5 'Easy reading – service users can carry the book with them'

	'But small characters + title to be covered'
Did the book provide good practical tips to tackle the alcohol problems?	Yes 4
Did this book encourage you to try out new things?	Yes 4
Since reading the book have you tried out any of the new skills suggested?	Yes 2 (service users) No 2 (staff)
Which tips /advice/skills did you find most useful?	'what do I say and do at a drinking party? P65 this is a high risk situation and nearly everyone socialises especially Christmas, birthdays and holidays. The advice is realistic let people if possible in advance know you are abstinent and or go with an abstinent friend. This is after some sober time has elapsed with you maintaining being sober' 'questions often asked by new non drinkers & pages that offer some answers (beginning of the book); generally the encouragement to visit AA meetings to build up a social support network with other people who went through the same experience + service users can turn to when in a crisis'; Chapter 6 pages 16-17 Chapter 8 pages 20-21 Chapter 23 pages 58-59
Has this book changed your view of drinking and how to deal with it? (client)	---
Overall, how useful was this book?	2 s.u. av. score = 10 2 staff av. score = 8 Tot av. score = 8.7
What is/are the most useful chapters of this book and why?	The 24 plan p6 – it gives really powerful advice such as breaking up 24 hours e.g. you can vow to not drink for 2 hours then the next 2 hours and so on; Changing the small things such as routine matters greatly, the routine goes hand in hand with any addiction p20 as well as your life style. Chapt.6 pag.13 A&B – getting active Chapt.8 pag.19 – changing old routines Chapt.14 pag.33 – fending off loneliness Chapt.15 pag.37 – watching out for anger and resentment Chapt.16 pag.40 – being good to yourself; I think all chapters have a valuable role but chapters 25 to 27 most useful: 25 looks at awareness but introduction ….

	(?) of change contrasted with past learned behaviour
And what was not so helpful?	At a party you won't find much committed tee-totalkers. So sometimes is best to avoid totally. There is no audio version for people with special needs. The book sometimes seems more problem focused rather than solution focused (view of alcoholism as an unchangeable and untreatable disorder); There is no space for service users' comments, no exercise sheets, no bullet pointed summaries, no highlighted sections; Maybe the depth of the book in content No diagrams/pictorial content/maps to make book more interesting, provide visualisation of certain examples/concepts
Do you think that we should offer this book to all service users during their treatment?	Yes 3
Would you recommend it to a friend? (client)	--- It will encourage me to visit AA meetings thus building up support network with people that understand and I can turn to in a crisis'
Would you use this book alongside your own key work? (staff)	Yes 2 Would look to introduce book but would need to consider the ability of person to understand and work with it. Not suited to high level or complex need but would be useful in detox/rehab/aftercare setting
Do you think it would be helpful to have this book in the local library?	Yes 4
Do you think that this book was worth the money?	Yes 4
Would you buy/recommend to buy this book?	Yes 4
Additional comments	'The book is broken down in small chapters so you can manage to read it on a daily basis. The book also teaches you to practice healthy substitutes. The book is realistic about not having male female sponsors for obvious reasons. The book is like a tee-total companion'. [not as good as bastards] Although this book is not as a practical guide as other self-help books I have read, it is relevant to recovery and useful for service users who are ready to make changes and for the ones who are still contemplating

	changes. Strengths of the book: It is written by people who used to have alcohol problems -> personal experience of authors; Normalisation and externalisation of the problem -> giving responsibility back to the reader/service user

Get your loved one sober: Alternatives to Nagging, Pleading, and Threatening'

To help people seeking sobriety for their loved ones, Get Your Loved One Sober offers a revolutionary program: The Community Reinforcement And Family Training (CRAFT) intervention. The subtitle, Alternatives to Nagging, Pleading, and Threatening more aptly describes what this book is about. Getting a loved one into treatment is not the first goal. Arranging for one's own safety and finding a happier life independent of the drinker's situation, takes priority. Getting a loved one to moderate, choose sobriety, or go into treatment, are offered as roads to a better relationship.

The CRAFT program is based on supportive and non-confrontational behavioral principles like reinforcement. It gives the reader tools and instructions for changing their interactions with their loved ones, which in turn changes the loved one's behavior. The book suggests the reader look for treatment that helps the drinker "figure out the triggers (stimulus cues) and reinforcers of his unhealthy behavior."

Get Your Loved One Sober, in an easy engaging presentation (friendly, accessible, do-it-yourself format), offers an organized tool kit of helpful behavioral strategies and realistic encouragement to apply these tools while dropping the often overused and ineffective nagging, pleading and threatening. Using simple terms and metaphors, dramatic story examples and hands-on activities, the book teaches the skills professionals call: behavioral analysis, goal setting, reinforcement and extinction, problem solving and communication.

How interesting was the book?	2 s.u. av. score = 8.5 2 staff av. score = 9 Tot av. score = 8.75
Length of the book	too long 4 'Would not get to the point. Kept repeating'. too short just about right
How easy was the book to read?	2 s.u. av. score = 8 2 staff av. score = 7.5 Tot av. score = 7.75
Did the book provide good practical tips to tackle the alcohol problems?	Yes 4
Did this book encourage you to try out new things?	Yes 3
Since reading the book have you tried out any of the new skills suggested?	Yes 2 No 1
Which tips /advice/skills did you find most useful?	page 177 priorities looking after yourself keeping strong physically and mentally if at all possible. But how does one do this when the money is gone, kids are in ragged clothes, holes in their shoes and debts; - practical tips – chapter 3

	- wishes vs goals (behaviours) – pages 68, 69, 75, 76 - instilling hope/positive - pages 76, 77 - 'PIUS' communication (Positive statements, begin with I, show Understanding, demonstrate a willingness to Share responsibility for the situation) – pages 134, 138-140, 155, 175, 177, 179, 183 - each chapter has RECAPS/ACTION SUMMARIES at the end; Chapter 7 p. 109 disable the enabling Page 19 the road map Both chapters will allow the family/carer to disassociate and see the bigger picture Chapter 2 – The road map Chapter 4 – Pick a destination (pages 70-76) Chapter 12 – Relapse prevention (pages 187-190)
Has this book changed your view of drinking and how to deal with it? (client)	No 1
Overall, how useful was this book?	2 s.u. av. score = 9 2 staff av. score = 7 'useful for carers' Tot av. score = 8
What is/are the most useful chapters of this book and why?	Page 47 play it safe Page 54 recognise the red flags; Chapter 3 – play it safe Chapter 6 – let the good times roll Chapter 7 – disable the enabling Chapter 8 – problem solving Chapter 9 – communication Chapter 10 – behaviour basics (good summary of all the techniques learnt in previous chapters) Chapter 12 – relapse prevention; P47-65 definition of violence – really good to extract as a checklist to discuss with family and carers Chapter 2 – The road map pages 21-25. makes you realise the pattern that the drinker follows Chapter 5 – the driver's seat pages 83-93. gives you a bit of a confidence boost to think that none of this is your fault.
And what was not so helpful?	Only focuses on alcohol, but could be applied to any other drug; Chapter 11 treatment – most of the book was done as outpatients / readers here may not relate to it as inpatients. The book is too long
Do you think that we	Yes 3

should offer this book to all service users during their treatment?	No 1
Would you recommend it to a friend? (client)	Yes 2
Would you use this book alongside your own key work? (staff)	Yes 2 It would be helpful for sessions where the carer is involved; Useful tips would need a lot of work to do this with family and carers. Helpful if you could extract model and its key features for keyworkers to understand and implement
Do you think it would be helpful to have this book in the local library?	Yes 3 No 1
Do you think that this book was worth the money?	Yes 2
Would you buy/recommend to buy this book?	Yes 3
Additional comments	[explained on the phone that found difficult to read it all – brought back sad memories]; - very good and enjoyable book – well written, easy, clear - style and approach ++ - instils hope, empathic - both for carers of people who are not ready to change yet, and for people who are well motivated - based on evidence-base -> Community reinforcement and Family Training (CRAFT) - good metaphor of road map/journey + realistic expectations - examples of other people's experiences/successes -> hope - examples of people the authors have worked with - uniqueness of the reader – not seen as 'average' client - externalises the problem (fight the problem, not the drinker); This book was written for US adults highly functioning (most have jobs and families) who are in the majority none dependent drinkers but are hazardous and heavy at risk drinkers. Our service users are very different. Family and carers may not be able to relate to US stories.

	Personally I would like to have read this book at the beginning of his treatment (referring to her son). I feel that I would have been helping him sooner or that I would have understood a lot more of what we were both going through, a lot sooner. The book is geared to more of a wife + husband scenario.

What's your reason: a practical guide to recovery

A new publication on recovery and self-help for people with addiction problems, written by staff in SLaM's addictions team, is a step-by-step workbook to help those recovering from alcohol or drug addiction. The book aims to help those recovering from an addiction to live the life they want – the essence of recovery and is divided into 5 categories, which together give someone a better chance of a sustained recovery.

How interesting was the book?	2 s.u. av. score = 8.5 2 staff av. score = 9 Tot 4 av. score = 8.75
Length of the book	too long too short just about right 4
How easy was the book to read?	2 s.u. av. score = 9 2 staff av. score = 10 Tot av. score = 9.5
Did the book provide good practical tips to tackle the alcohol problems?	Yes 4
Did this book encourage you to try out new things?	Yes 4
Since reading the book have you tried out any of the new skills suggested?	Yes 2
Which tips /advice/skills did you find most useful?	Helping to think about one's behaviour, thinking patterns and is solution focused rather than problem focused Each chapter has exercise sheet; the balance sheet p5 – simple way to set people's thinking about drug/usage tips to say 'no' p13 tips on dealing with cravings p19 keeping occupied p106, section 5.3; 2.1 page 33 the tips about healthy eating some I didn't know about Pag.20 1.5 I think the craving buster would have helped me in the past 4.31 I found the tips on dealing with panic very helpful; Useful contacts p 46 Social anxiety p 76 Mindfulness p 104
Has this book changed your view of drinking and how to deal with it?	Yes 2 I don't drink no more but found the information p.27

(client)	helpful and also like the goal planning page 2; Now that I'm abstaining from alcohol I can go ahead and do some goal-planning for my life
Overall, how useful was this book?	2 s.u. av. score = 9 2 staff av. score = 9.5 Tot av. score = 9.25
What is/are the most useful chapters of this book and why?	Overall most chapters are useful As they prompt reader to stop and think about possible reason for behaviours and offer space to reflect on them and think of different approaches/behaviours to try out; All the book is relevant to recovery but personally I feel that the book gives a simple overview of depression/anxiety/anger/bereavement – section 4 Dealing with cravings section 1.5 is very good; 4. 31, 4.32 1.7 4.6 helped me grasp a better understanding of what I have been through. Gives many pointers for help in these situations; Negative glasses page 101 (this is something I tend to do)
And what was not so helpful?	At times the spaces left for clients' comments did not seem large enough for ideas/comments that clients may have – perhaps tables could be enlarged and photocopied for clients; Well, to me all the phone numbers. But maybe useful to someone who has just started looking for help; Found whole book very helpful
Do you think that we should offer this book to all service users during their treatment?	Yes 4
Would you recommend it to a friend? (client)	Yes 2 Very useful book for someone in recovery because the feelings you have mean you are not just mad
Would you use this book alongside your own key work? (staff)	Yes 2 Gives good grounds for k/w sessions and topics to be explored in more detail; Very practical guide – could be used with key work sessions to reflect on progress, barriers to recovery and dealing with co-morbid problems (anxiety, anger, depression)
Do you think it would be helpful to have this book in the local library?	Yes 4
Do you think that this book was worth the money?	Yes 1 n/a 2 - no price given
Would you buy/recommend to buy this book?	Yes 4 but could it be given out free as slam booklet
Additional comments	I like this book, I think it is useful for clients ready to

	make changes and ones who are still contemplating changes to guide through think process; A very clearly written book. It is so simple to read and it is a book you can dip in and out as well as reading it cover to cover; It's a good all round book which covers all different problems for different people, especially someone who has been in same situation as me. [Good cover – people would not understand the content of the book -> service users would be comfortable in carrying the book around with them]; I enjoyed this book very much. Most of the chapters applied to me so I can look at my issues from a different angle now that I'm sober.

Overcoming problem drinking: A self-help guide using CBT

This first self-help book aimed specifically at problem drinking uses an approach based on real clinical practice, first to help the reader recognise alcohol misuse and then, using proven CBT techniques, to show him/her how to turn the tables and regain control of alcohol consumption. For anyone who feels alcohol is beginning to rule their lives, this is an indispensable guide, combining the expertise of psychologists and those working in the medical profession. It also shows how to enlist the help of friends and family.

The author is a Senior Lecturer in Psychology and a psychotherapist. He has extensive experience working with problem drinking having worked for four years as an alcohol counselor and has written a number of academic articles on alcohol use and drinking behaviour.

How interesting was the book?	2 s.u. av. score = 7.5 2 staff av. score = 7.5 Tot av. score = 7.5
Length of the book	too long 3 too short just about right 1
How easy was the book to read?	2 s.u. av. score = 5.5 2 staff av. score = 6.5 Tot av. score = 6
Did the book provide good practical tips to tackle the alcohol problems?	Yes 3
Did this book encourage you to try out new things?	Yes 3
Since reading the book have you tried out any of the new skills suggested?	Yes 2 (clients) No 2 (staff)
Which tips /advice/skills did you find most useful?	Exercise pages 35-36 is very simple and clear Likewise exercise 2 pages 39-44; Drinking diary, problems – targets analysis Increasing pleasurable activities Relaxation tips Control drinking skills; Challenging positive thoughts about drinking –chapter 4 Tackling craving – chapter 10 All of the exercise tables
Has this book changed your view of drinking and how to deal with it? (client)	Yes 2 Yes, it has shown me that it is not a good thing to drink in order to cope with problems, it only makes things worse, in terms of lowering mood and increasing anxiety. I didn't read much of it as it was too long but what I found was interesting is how alcohol can affect people in

	different ways
Overall, how useful was this book?	2 s.u. av. score = 7 2 staff av. score = 5 Tot av. score = 6
What is/are the most useful chapters of this book and why?	'Better than identifying chapters, I would say that the most useful parts of the book are the exercises, the highlighted sections, and the bullet pointed summaries. Those are the practical things clients can do, and the client is given a concise picture of what the book is about'; Early chapters 1 – 3 understand the problem 5 – enhancing motivation to change 8 – challenging permissive thoughts 10 – tackling cravings 12 – key skills 13 – pleasurable activities 15 – moderating drinking 16 – preventing slips Appendix – recreation and improving sleep; 9 + 10 they provided a lot of insight and useful tips and coping strategies;
And what was not so helpful?	'I think the book is overlong. It has words and sentences which I believe the majority of our client group would find difficult'; 'Too many different concepts and theories. Reads like a text book not a self help book. Will be difficult for people with disordered lives and less intellectual capabilities'; n/a Too small print, sentences too long
Do you think that we should offer this book to all service users during their treatment?	Yes 2 No 2 (staff)
Would you recommend it to a friend? (client)	Yes 2 I would because it gives an insight of what people can and explain how this horrible liquid can affect different people in different ways
Would you use this book alongside your own key work? (staff)	Yes 1 No 1 'Following on my comments on Q10, I think this book would be a useful tool for a key worker who could adapt it and print out the exercises and summaries'; 'I will have to use this based on the cognitive functioning and intellectual capabilities of the specific individual. So my answer is yes to some and no to others'.
Do you think it would be	Yes 3

helpful to have this book in the local library?	
Do you think that this book was worth the money?	Yes 2 No 2
Would you buy/recommend to buy this book?	Yes 2 No 1 - depends on which client, not everyone
Additional comments	'For the reasons given above, I think a lot of service users would struggle with large parts of this book, and £10.99 is quite a big investment. For those who are motivated to read it in full, having it in the local library would be useful': 'Useful for some service users depending on stage and level of use. Also individual cognition and intellectual capabilities. Individual will have to be disciplined with self control. Also be ready to seek change. Needs inner motivation. Some words are too big and difficult for the average person to grasp. This book on its own without a professional explaining to the reader some of the concepts could actually confuse some rather than help to help themselves'. I think that the length of the book was too long but did have some pics/diagrams in it but for the price I think is a bit too much.